

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10964

10992 CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Mr. Joseph Henry Albers</u>		4. DATE OF DEATH <u>November 30th 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Genl Hospt</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Henry Albers</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bauer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Gertrude M. Albers, Jarrettsville Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic heart disease</u> DUE TO (c) <u>12 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 w b</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 13, 1956</u> to <u>Nov. 30, 1956</u> , that I last saw the deceased alive on <u>Nov. 24, 1956</u> , and that death occurred at <u>5:28 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles A. Neff</u> M.D.		ADDRESS (Street, city or town, state) <u>STREET, MD</u> DATE SIGNED <u>Nov. 30, 1956</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES A. NEFF M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road.</u>	
24a. REC'D BY REGISTRAR <u>DEC 3 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Ely. Gouchy</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10993 CERTIFICATE OF DEATH

10965

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MD</u>		COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		LENGTH OF STAY (in this place) <u>3 YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>804 MYRTH AVE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LOUIS</u> (Middle) <u>C.</u> (Last) <u>AMICONE</u>				(Month) <u>11</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>7/2/1892</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMAMELER STANDARD RADIOS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CO</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL AMICONE</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>M. G. AMICONE 804 MYRTH AVE</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO <u>arteriosclerotic heart</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>disease.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> Jan at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 18, 1947</u> , to <u>Nov. 23, 1956</u> , that I last saw the deceased alive on <u>Nov 15, 1956</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. A. Flanagan Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>3501 Jait Ave.</u>		DATE SIGNED <u>11/24/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>NOV 27 1956</u>		REGISTRAR'S SIGNATURE <u>Edith Hardy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Blarune F. Hoffmann</u>		ADDRESS <u>3718 Hudson St</u>	

BUREAU V. S.

NOV 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10994

CERTIFICATE OF DEATH

10966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 35 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last ANDERSON, JR.				4. DATE OF DEATH Month November Day 6 Year 19 56			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 22, 1894	
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Naval Academy		11. BIRTHPLACE (State or foreign country) Conowingo, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John E. Anderson				14. MOTHER'S MAIDEN NAME Anna Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Post operative wound infection, left herniorrhaphy incision. 2. Left hydrocele INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 2, 1956 , to November 6, 1956 , and that death occurred at 9:35 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fort Howard, Maryland DATE SIGNED 11/7/56							
ACTUAL SIGNATURE C. J. Papastrat M.D. M.D. VAH, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF Nov 11 1956							
22c. NAME OF CEMETERY OR CREMATORY Mount Tabor Cemetery							
22d. LOCATION (City, town, or county) (State) Anne Arundel Co., Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE J. B. Johnson Funeral Home, 34 Lafayette St. Annapolis, Md.							
24a. REC'D BY REGISTRAR Nov 8, 1956							
24b. REGISTRAR'S SIGNATURE Lawson L. Farber							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED JAMES EARL RAY		SEX Male		AGE 35 Years		OCCUPATION Attorney		COUNTY St. Louis	
PLACE OF BIRTH Jackson, Mississippi		DATE OF BIRTH May 19, 1928		PLACE OF DEATH St. Louis, Missouri		DATE OF DEATH May 14, 1968		TIME OF DEATH 11:00 AM	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF INTERMENT St. Louis, Missouri		DATE OF INTERMENT May 16, 1968		TIME OF INTERMENT 10:00 AM	
SIGNATURE OF DECEASED James Earl Ray		SIGNATURE OF WITNESS John H. Johnson		SIGNATURE OF PHYSICIAN John H. Johnson		SIGNATURE OF CLERK John H. Johnson		SIGNATURE OF REGISTRAR John H. Johnson	
SIGNATURE OF DECEASED James Earl Ray		SIGNATURE OF WITNESS John H. Johnson		SIGNATURE OF PHYSICIAN John H. Johnson		SIGNATURE OF CLERK John H. Johnson		SIGNATURE OF REGISTRAR John H. Johnson	

BUREAU V. S.

NOV 9 1968

RECEIVED

10995 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEO Middle (NMI) Last ANTOS				4. DATE OF DEATH Month November Day 24 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/11/91	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Tailor Shop		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Antos				14. MOTHER'S MAIDEN NAME Mary Neuman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 215-09-1150		17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED						INTERVAL BETWEEN ONSET AND DEATH 15 hours 9 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, GENERALIZED						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 22, 1956 to November 24, 1956 that I saw the deceased alive on November 24, 1956 and that death occurred at 2:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 11/25/56							
ACTUAL SIGNATURE Constantine J. Papastreat				PHYSICIAN'S NAME (Type) CONSTANTINE J. PAPASTREAT, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-28-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Im-Cook-Blight Fun. Home				ADDRESS 6009 Harford Rd., Balto. Md.		24a. REC'D BY REGISTRAR DEC 3 1956	
				24b. REGISTRAR'S SIGNATURE Russell L. Fink			

MEDICAL CERTIFICATION

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10996 CERTIFICATE OF DEATH

10968.

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>3428 Childs Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>(NMI)</u> Last <u>ATKINSON, Jr.</u>				4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/9/24</u>	
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas Atkinson, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Maude Calhoun</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII</u>				16. SOCIAL SECURITY NO. <u>256-22-9337</u>		17. INFORMANT <u>Clin.Recs.Vets.Admin.Hospital,Ft.Howard,Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RETROPERITONEAL SARCOMA</u> DUE TO <u>158X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>October 30</u> , 19 <u>56</u> , to <u>November 9</u> , 19 <u>56</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Veterans Administration Hospital</u> DATE SIGNED <u>11/11/56</u> ACTUAL SIGNATURE <u>C. J. Papastrat</u> M.D. <u>Veterans Administration Hospital</u> PHYSICIAN'S NAME (Type) <u>C. J. PAPASTRAT, M.D.</u> <u>Fort Howard, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>Law Mortuary 802-04 Madison Ave. Balto. Md.</u>				24a. REC'D BY REGISTRAR <u>Dawson L. Farber</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farber</u>	

10997

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Co. Hospital				d. STREET ADDRESS 3912 Pulaski Highway			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBERT Middle G. Last Bach				4. DATE OF DEATH Month 11 - Day 30 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 1, 1917	
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRAKEMAN		10b. KIND OF BUSINESS OR INDUSTRY R. R. SPARROWS PT.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME FRANK BACH				14. MOTHER'S MAIDEN NAME ROSE BECKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WORLD WART		17. INFORMANT MARIE J. BARRETT		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury of Pelvis 800.X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Accidentally Caught between two DUE TO (c) railroad Cars. INTERVAL BETWEEN ONSET AND DEATH 10 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Caught between two RR Cars -					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 11-30 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Steel Mill		20f. (City or town) (County) (State) Sparrows Pt 19 Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JACK C COLLINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-4-56		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NAT. CEM.		22d. LOCATION (City, town, or county) (State) 5501 FREDERICK AVE.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Guler				ADDRESS 901 S. CONKLING ST. BALTO, MD.		24a. REC'D BY REGISTRAR DATE Dec 3, 1956	
				24b. REGISTRAR'S SIGNATURE James L. Barber			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the registration number prior to burial, cremation, or removal.

DEC 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10998 CERTIFICATE OF DEATH

10970
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 611 N. AUGUSTA AVENUE	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle M. Last BAGNALL		4. DATE OF DEATH Month November Day 5 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-80
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Oil Company	
11. BIRTHPLACE (State or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT G. BAGNALL		14. MOTHER'S MAIDEN NAME AMANDA MYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RECTUM WITH METASTASIS TO LIVER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 154X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		Operation: 10/30/56 Sigmoid Colostomy-Carcinoma, rectum	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 12 , 19 56 , to Nov. 5 , 19 56 , and that death occurred at 5:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 11/6/56 ACTUAL SIGNATURE Milton Ginsberg M.D. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D., Acting Chief, Surgical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/8/56	
22c. NAME OF CEMETERY OR CREMATORY DOUDON PARK CREMATORY		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Tickner & Sons, North & Pennsylvania Aves., Baltimore, Maryland		24a. READ BY REGISTRAR Mr. J. 1956	
24b. REGISTRAR'S SIGNATURE Lawson L. Farber			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 8 AON

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10971

10999 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Penn. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lovely				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phila.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pulaski Highway				d. STREET ADDRESS 2216 N. Cleveland St.			
3. NAME OF DECEASED (Type or print) First Middle Last IRA BANKS				4. DATE OF DEATH Month Day Year Nov. 26 19 56			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1916	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Cape Charles, Va.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George R. Banks				14. MOTHER'S MAIDEN NAME Awilda			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Alston Goodwin Cape Charles, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head injury 816 X DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushing injury of chest DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-truck collision 20c. TIME OF INJURY Month, Day, Year Hour xxx 11:30 p. m. 11/25/ 1956 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street 20f. (City or town) (County) (State) Balto. Md.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Motored				22b. DATE THEREOF 11/26/56		22c. NAME OF CEMETERY OR CREMATORY Cape Charles, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams				ADDRESS		24a. REC'D BY REGISTRAR Nov. 28, 56	
						24b. REGISTRAR'S SIGNATURE Huntington Wms., M.D.	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Last Name		First Name		Middle Name	
George R. Banks		Banks		George		R.	
Race		Color		Sex		Age	
Colored		Male		Male		32	
Date of Death		Place of Death		Cause of Death		Manner of Death	
June 9, 1956		Home		Heart injury		Accident	
U.S.A.		Cape Charles, Va.		Cape Charles, Va.		Cape Charles, Va.	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Cause of Report		Manner of Report	
June 10, 1956		Home		Heart injury		Accident	
U.S.A.		Cape Charles, Va.		Cape Charles, Va.		Cape Charles, Va.	

BUREAU V. 2

DEC 4 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11000

CERTIFICATE OF DEATH

10972

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
c. LENGTH OF STAY IN 1b 4mth12dys		d. STREET ADDRESS 4601 Pall Mall Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isaac Middle Bartz Last Bartz		4. DATE OF DEATH Month November Day 15 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1880?
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Acute cardiac failure DUE TO (c) Arteriosclerotic cardiovascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 9, 1956 , to Nov. 15, 1956 , that I last saw the deceased alive on Nov. 15, 1956 , and that death occurred at 9:05a M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler M.D.		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 11-15-56	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	11-16-56	Rosedale	Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		24a. REC'D BY REGISTRAR NOV 16 1956	
ADDRESS 2100 Cuttaw Place		24b. REGISTRAR'S SIGNATURE F. E. Barry	

RECEIVED

NOV 16 1955

BUREAU V. S.

MARRIAGE STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED: [illegible]	
2. SEX: [illegible]	
3. DATE OF BIRTH: [illegible]	
4. PLACE OF BIRTH: [illegible]	
5. OCCUPATION: [illegible]	
6. MARITAL STATUS: [illegible]	
7. CAUSE OF DEATH: [illegible]	
8. PLACE OF DEATH: [illegible]	
9. TIME OF DEATH: [illegible]	
10. SIGNATURE OF DECEASED: [illegible]	
11. SIGNATURE OF WITNESS: [illegible]	
12. SIGNATURE OF PHYSICIAN: [illegible]	
13. SIGNATURE OF CLERK: [illegible]	
14. SIGNATURE OF JUDGE: [illegible]	
15. SIGNATURE OF NOTARY: [illegible]	
16. SIGNATURE OF DECEASED: [illegible]	
17. SIGNATURE OF WITNESS: [illegible]	
18. SIGNATURE OF PHYSICIAN: [illegible]	
19. SIGNATURE OF CLERK: [illegible]	
20. SIGNATURE OF JUDGE: [illegible]	
21. SIGNATURE OF NOTARY: [illegible]	
22. SIGNATURE OF DECEASED: [illegible]	
23. SIGNATURE OF WITNESS: [illegible]	
24. SIGNATURE OF PHYSICIAN: [illegible]	
25. SIGNATURE OF CLERK: [illegible]	
26. SIGNATURE OF JUDGE: [illegible]	
27. SIGNATURE OF NOTARY: [illegible]	
28. SIGNATURE OF DECEASED: [illegible]	
29. SIGNATURE OF WITNESS: [illegible]	
30. SIGNATURE OF PHYSICIAN: [illegible]	
31. SIGNATURE OF CLERK: [illegible]	
32. SIGNATURE OF JUDGE: [illegible]	
33. SIGNATURE OF NOTARY: [illegible]	
34. SIGNATURE OF DECEASED: [illegible]	
35. SIGNATURE OF WITNESS: [illegible]	
36. SIGNATURE OF PHYSICIAN: [illegible]	
37. SIGNATURE OF CLERK: [illegible]	
38. SIGNATURE OF JUDGE: [illegible]	
39. SIGNATURE OF NOTARY: [illegible]	
40. SIGNATURE OF DECEASED: [illegible]	
41. SIGNATURE OF WITNESS: [illegible]	
42. SIGNATURE OF PHYSICIAN: [illegible]	
43. SIGNATURE OF CLERK: [illegible]	
44. SIGNATURE OF JUDGE: [illegible]	
45. SIGNATURE OF NOTARY: [illegible]	
46. SIGNATURE OF DECEASED: [illegible]	
47. SIGNATURE OF WITNESS: [illegible]	
48. SIGNATURE OF PHYSICIAN: [illegible]	
49. SIGNATURE OF CLERK: [illegible]	
50. SIGNATURE OF JUDGE: [illegible]	
51. SIGNATURE OF NOTARY: [illegible]	
52. SIGNATURE OF DECEASED: [illegible]	
53. SIGNATURE OF WITNESS: [illegible]	
54. SIGNATURE OF PHYSICIAN: [illegible]	
55. SIGNATURE OF CLERK: [illegible]	
56. SIGNATURE OF JUDGE: [illegible]	
57. SIGNATURE OF NOTARY: [illegible]	
58. SIGNATURE OF DECEASED: [illegible]	
59. SIGNATURE OF WITNESS: [illegible]	
60. SIGNATURE OF PHYSICIAN: [illegible]	
61. SIGNATURE OF CLERK: [illegible]	
62. SIGNATURE OF JUDGE: [illegible]	
63. SIGNATURE OF NOTARY: [illegible]	
64. SIGNATURE OF DECEASED: [illegible]	
65. SIGNATURE OF WITNESS: [illegible]	
66. SIGNATURE OF PHYSICIAN: [illegible]	
67. SIGNATURE OF CLERK: [illegible]	
68. SIGNATURE OF JUDGE: [illegible]	
69. SIGNATURE OF NOTARY: [illegible]	
70. SIGNATURE OF DECEASED: [illegible]	
71. SIGNATURE OF WITNESS: [illegible]	
72. SIGNATURE OF PHYSICIAN: [illegible]	
73. SIGNATURE OF CLERK: [illegible]	
74. SIGNATURE OF JUDGE: [illegible]	
75. SIGNATURE OF NOTARY: [illegible]	
76. SIGNATURE OF DECEASED: [illegible]	
77. SIGNATURE OF WITNESS: [illegible]	
78. SIGNATURE OF PHYSICIAN: [illegible]	
79. SIGNATURE OF CLERK: [illegible]	
80. SIGNATURE OF JUDGE: [illegible]	
81. SIGNATURE OF NOTARY: [illegible]	
82. SIGNATURE OF DECEASED: [illegible]	
83. SIGNATURE OF WITNESS: [illegible]	
84. SIGNATURE OF PHYSICIAN: [illegible]	
85. SIGNATURE OF CLERK: [illegible]	
86. SIGNATURE OF JUDGE: [illegible]	
87. SIGNATURE OF NOTARY: [illegible]	
88. SIGNATURE OF DECEASED: [illegible]	
89. SIGNATURE OF WITNESS: [illegible]	
90. SIGNATURE OF PHYSICIAN: [illegible]	
91. SIGNATURE OF CLERK: [illegible]	
92. SIGNATURE OF JUDGE: [illegible]	
93. SIGNATURE OF NOTARY: [illegible]	
94. SIGNATURE OF DECEASED: [illegible]	
95. SIGNATURE OF WITNESS: [illegible]	
96. SIGNATURE OF PHYSICIAN: [illegible]	
97. SIGNATURE OF CLERK: [illegible]	
98. SIGNATURE OF JUDGE: [illegible]	
99. SIGNATURE OF NOTARY: [illegible]	
100. SIGNATURE OF DECEASED: [illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11001 CERTIFICATE OF DEATH

10973

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>4044 Wilkins Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>EMORY</u> Middle <u>E</u> Last <u>BEACH</u>		4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/18</u>
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware Supply</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Beach</u>		14. MOTHER'S MAIDEN NAME <u>Anna Elizabeth Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>218-01-3610</u>	
17. INFORMANT <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 18, 1956</u> to <u>November 24, 1956</u> , that I last saw the deceased alive on <u>November 19, 1956</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Godfrey</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Veterans Administration Hospital 11/25/56</u>	
PHYSICIAN'S NAME (Type) <u>G. GODFREY, M.D.</u>		<u>Fort Howard, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-28-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Truman Schwab</u>		24a. REC'D BY REGISTRAR <u>Nov 27 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Dawson L. Lacey</u>			

CERTIFICATE OF DEATH

Date of Birth Sex Race Color Marital Status Occupation Education Religion Usual Residence Date of Death Place of Death Cause of Death Manner of Death Burial Place Burial Date Burial Time Burial Person Signature of Registrar Signature of Physician Signature of Coroner Signature of Medical Examiner Signature of Pathologist Signature of Toxicologist Signature of Chemist Signature of Microscopist Signature of Radiologist Signature of Pathologist Signature of Toxicologist Signature of Chemist Signature of Microscopist Signature of Radiologist		Date of Birth Sex Race Color Marital Status Occupation Education Religion Usual Residence Date of Death Place of Death Cause of Death Manner of Death Burial Place Burial Date Burial Time Burial Person Signature of Registrar Signature of Physician Signature of Coroner Signature of Medical Examiner Signature of Pathologist Signature of Toxicologist Signature of Chemist Signature of Microscopist Signature of Radiologist Signature of Pathologist Signature of Toxicologist Signature of Chemist Signature of Microscopist Signature of Radiologist
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BUREAU Y. 8

NOV 27 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11002

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10974

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY <i>Ba/to</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Ceset</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ceset</i>		c. LENGTH OF STAY IN 1b <i>44 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ceset - Rural</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>409 Back River Neck Rd.</i>				d. STREET ADDRESS <i>409 Back River Neck</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>Isabelle</i> Last <i>Bedford</i>				4. DATE OF DEATH Month <i>11</i> Day <i>18</i> Year <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <i>74</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Carroll Co. MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Borden Brown</i>				14. MOTHER'S MAIDEN NAME <i>Olivia J. Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular Dis</i> DUE TO (c) <i>44 yrs</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Jack C. Collins</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>JACK C. COLLINS</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>11-21-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St Stevens md</i>		22d. LOCATION (City, town, or county) (State) <i>Ceset md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>1000</i> <i>Chay O. Wilson</i>				24a. REC'D BY REGISTRAR DATE <i>11-23-56</i>		24b. REGISTRAR'S SIGNATURE <i>Edith Hurley</i>	

MEDICAL CERTIFICATION

1000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF TEXAS
COUNTY OF DALLAS

BUREAU V. S.

NOV 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filled with the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11003 CERTIFICATE OF DEATH

Reg. Dist. No.

1097544

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lodge Forest Home		d. STREET ADDRESS 1908 Wareham Avenue	
3. NAME OF DECEASED (Type or print) First Anna Middle A. Last Belitski		4. DATE OF DEATH Month November Day 4 Year 1956	
5. SEX F	6. COLOR OR RACE Ca u	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1870
9. AGE (In years less birthday) yrs. 86		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Chaney		14. MOTHER'S MAIDEN NAME Evelyn Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Wilbur Kellum		Address 1908 Wareham Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) White Coronary Insufficiency 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Ht. Disease DUE TO (c) Serious Mellitus		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 4 yrs 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 56 , to Nov 4 , 19 56 , that I last saw the deceased alive on Nov 4 , 19 56 , and that death occurred at 2 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Means		ADDRESS (Street, city or town, state) 570 D St Baltimore Md	
PHYSICIAN'S NAME (Type) James T. Means		DATE SIGNED 11/6/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Nov. 7, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Parkville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		ADDRESS 4210 Belair Road	
24a. REC'D BY REGISTRAR NOV 8 1956		24b. REGISTRAR'S SIGNATURE Lawson Larkins	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1900		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
LABORER		HEART DISEASE		NATURAL		2 WEEKS		JAN 20 1956		BALTIMORE		MD		MD	
EDUCATION		SCHOOLING		RELIGION		RACE		COLOR		SEX		AGE		DATE OF BIRTH	
HIGH SCHOOL		8 YEARS		METHODIST		WHITE		WHITE		MALE		45		JAN 15 1900	
MARRIAGE		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAN 15 1925		BALTIMORE		MD		MD		USA		JAN 20 1956		BALTIMORE		MD	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAN 20 1956		BALTIMORE		MD		MD		USA		JAN 20 1956		BALTIMORE		MD	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAN 20 1956		BALTIMORE		MD		MD		USA		JAN 20 1956		BALTIMORE		MD	

BUREAU V. 2

NOV 9 1956

RECEIVED

11004 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 4527 Arabia Avenue - Balto. Md.	
3. NAME OF DECEASED (Type or print) First Thomas Middle Last Bily		4. DATE OF DEATH Month November Day 28 , Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1880
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) conduit layer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Bohemia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Bily		14. MOTHER'S MAIDEN NAME Mary Stulik	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess left temporal lobe due to 3921 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic purulent mastoiditis DUE TO (c) Chronic suppurative otitis media			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 24, 19 56 , to Nov. 28, 19 56 , that I last saw the deceased alive on Nov. 28, 19 56 , and that death occurred at 5:10 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 11-29-56 PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Duppe Bros. 7110 Belair Rd		24a. REC'D BY REGISTRAR DEC 3 1956	
24b. REGISTRAR'S SIGNATURE F. G. Harry			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Form 100

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]		9. MANNER OF DEATH [Illegible]	
10. SIGNATURE OF PHYSICIAN [Illegible]		11. SIGNATURE OF REGISTRAR [Illegible]		12. SIGNATURE OF WITNESS [Illegible]	
13. DATE OF DEATH [Illegible]		14. PLACE OF DEATH [Illegible]		15. TIME OF DEATH [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF NEXT OF KIN [Illegible]		18. SIGNATURE OF BURIAL OFFICIAL [Illegible]	
19. SIGNATURE OF MINISTER OF GOSPEL [Illegible]		20. SIGNATURE OF CHURCH CLERK [Illegible]		21. SIGNATURE OF FUNERAL HOME [Illegible]	
22. SIGNATURE OF CEMETERY CLERK [Illegible]		23. SIGNATURE OF INTERVIEWER [Illegible]		24. SIGNATURE OF SUPERVISOR [Illegible]	
25. SIGNATURE OF ASSISTANT SUPERVISOR [Illegible]		26. SIGNATURE OF CLERK [Illegible]		27. SIGNATURE OF RECEPTIONIST [Illegible]	
28. SIGNATURE OF TELEPHONE OPERATOR [Illegible]		29. SIGNATURE OF MAIL ROOM [Illegible]		30. SIGNATURE OF RECORDS SECTION [Illegible]	
31. SIGNATURE OF IDENTIFICATION SECTION [Illegible]		32. SIGNATURE OF LABORATORY [Illegible]		33. SIGNATURE OF RADIOLOGY [Illegible]	
34. SIGNATURE OF PATHOLOGY [Illegible]		35. SIGNATURE OF BACTERIOLOGY [Illegible]		36. SIGNATURE OF VIROLOGY [Illegible]	
37. SIGNATURE OF IMMUNOLOGY [Illegible]		38. SIGNATURE OF SEROLOGY [Illegible]		39. SIGNATURE OF CYTOLOGY [Illegible]	
40. SIGNATURE OF HISTOLOGY [Illegible]		41. SIGNATURE OF ANATOMY [Illegible]		42. SIGNATURE OF PHYSIOLOGY [Illegible]	
43. SIGNATURE OF PSYCHOLOGY [Illegible]		44. SIGNATURE OF EDUCATION [Illegible]		45. SIGNATURE OF RESEARCH [Illegible]	
46. SIGNATURE OF PUBLIC HEALTH [Illegible]		47. SIGNATURE OF COMMUNITY HEALTH [Illegible]		48. SIGNATURE OF ENVIRONMENTAL HEALTH [Illegible]	
49. SIGNATURE OF OCCUPATIONAL HEALTH [Illegible]		50. SIGNATURE OF NUTRITION [Illegible]		51. SIGNATURE OF PHYSICAL EDUCATION [Illegible]	
52. SIGNATURE OF RECREATION [Illegible]		53. SIGNATURE OF ARTS AND CRAFTS [Illegible]		54. SIGNATURE OF MUSIC [Illegible]	
55. SIGNATURE OF THEATRE [Illegible]		56. SIGNATURE OF FILM [Illegible]		57. SIGNATURE OF TELEVISION [Illegible]	
58. SIGNATURE OF RADIO [Illegible]		59. SIGNATURE OF COMMERCE [Illegible]		60. SIGNATURE OF INDUSTRY [Illegible]	
61. SIGNATURE OF TRANSPORTATION [Illegible]		62. SIGNATURE OF AGRICULTURE [Illegible]		63. SIGNATURE OF FISHERY [Illegible]	
64. SIGNATURE OF MINING [Illegible]		65. SIGNATURE OF QUARRYING [Illegible]		66. SIGNATURE OF CONSTRUCTION [Illegible]	
67. SIGNATURE OF MANUFACTURING [Illegible]		68. SIGNATURE OF DISTRIBUTION [Illegible]		69. SIGNATURE OF RETAIL [Illegible]	
70. SIGNATURE OF WHOLESALE [Illegible]		71. SIGNATURE OF IMPORTATION [Illegible]		72. SIGNATURE OF EXPORTATION [Illegible]	
73. SIGNATURE OF FOREIGN TRADE [Illegible]		74. SIGNATURE OF INTERNATIONAL [Illegible]		75. SIGNATURE OF INTERSTATE [Illegible]	
76. SIGNATURE OF INTRASTATE [Illegible]		77. SIGNATURE OF LOCAL [Illegible]		78. SIGNATURE OF COUNTY [Illegible]	
79. SIGNATURE OF CITY [Illegible]		80. SIGNATURE OF TOWNSHIP [Illegible]		81. SIGNATURE OF VILLAGE [Illegible]	
82. SIGNATURE OF CENSUS [Illegible]		83. SIGNATURE OF VOTING [Illegible]		84. SIGNATURE OF ELECTION [Illegible]	
85. SIGNATURE OF JUDICIAL [Illegible]		86. SIGNATURE OF LEGISLATIVE [Illegible]		87. SIGNATURE OF EXECUTIVE [Illegible]	
88. SIGNATURE OF JUDICIAL [Illegible]		89. SIGNATURE OF LEGISLATIVE [Illegible]		90. SIGNATURE OF EXECUTIVE [Illegible]	
91. SIGNATURE OF JUDICIAL [Illegible]		92. SIGNATURE OF LEGISLATIVE [Illegible]		93. SIGNATURE OF EXECUTIVE [Illegible]	
94. SIGNATURE OF JUDICIAL [Illegible]		95. SIGNATURE OF LEGISLATIVE [Illegible]		96. SIGNATURE OF EXECUTIVE [Illegible]	
97. SIGNATURE OF JUDICIAL [Illegible]		98. SIGNATURE OF LEGISLATIVE [Illegible]		99. SIGNATURE OF EXECUTIVE [Illegible]	
100. SIGNATURE OF JUDICIAL [Illegible]		101. SIGNATURE OF LEGISLATIVE [Illegible]		102. SIGNATURE OF EXECUTIVE [Illegible]	

BUREAU V. S.

DEC 3 1956

RECEIVED

109778

11005 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

Mrs. Anna Ehrhardt Bishop

2. DATE
OF
DEATH

Nov. 24 1956

3. PLACE OF DEATH

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street address or location)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

420.0

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) DUE TO
(C)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐21a. TIME (Month) (Day) (Year) (Hour)
OF INJURY

m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19..... to
..... 19....., that (I) (we) last saw the deceased alive on 19.....,
and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

NOV 26 1956

Leonard J. Ruck 5305 Harford Road.

THIS IS A PERMANENT RECORD.
PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

MIL. CERTIFICATION

...I found after a few 25 sulfate treatments of the Rhesus blood cell with selenite and got MAXIMUM INHIBITION OF LANTHANUM OF ...

BUREAU OF THE ARMY

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10978

11006 CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 302 Dixie Drive				d. STREET ADDRESS 302 Dixie Drive #4			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROBERT Middle F. Last BONSALL				4. DATE OF DEATH Month Nov. Day 10 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1876		9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months 10 Days 19 Hours 56	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Ass't Treasury				10b. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Electric		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ? unknown				14. MOTHER'S MAIDEN NAME ? unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Address Mr. R. Stewart Bonsall-103 Tyrone Road #12			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Hemiplegia DUE TO Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from August 14, 1935 , to Nov 10, 1956 , that I last saw the deceased alive on 10th , 1956, and that death occurred at 2:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1820 Eulaw place DATE SIGNED Michael A. Abrams							
ACTUAL SIGNATURE Michael A. Abrams M.D.							
PHYSICIAN'S NAME (Type) Michael A. Abrams							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/56		22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Lickens & Sons				ADDRESS 1700 E. Baltimore 17. Md.		24a. REC'D BY REGISTRAR DATE Nov 13, 1956	
				24b. REGISTRAR'S SIGNATURE Markel Gray			

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Form No. 10

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>		<p>7. PLACE OF DEATH</p>		<p>8. CAUSE OF DEATH</p>		<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF REGISTRAR</p>		<p>11. SIGNATURE OF WITNESS</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. NAME OF DECEASED</p>		<p>14. SEX</p>		<p>15. AGE</p>		<p>16. DATE OF BIRTH</p>		<p>17. PLACE OF BIRTH</p>		<p>18. DATE OF DEATH</p>		<p>19. PLACE OF DEATH</p>		<p>20. CAUSE OF DEATH</p>		<p>21. MANNER OF DEATH</p>		<p>22. SIGNATURE OF REGISTRAR</p>		<p>23. SIGNATURE OF WITNESS</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. NAME OF DECEASED</p>		<p>26. SEX</p>		<p>27. AGE</p>		<p>28. DATE OF BIRTH</p>		<p>29. PLACE OF BIRTH</p>		<p>30. DATE OF DEATH</p>		<p>31. PLACE OF DEATH</p>		<p>32. CAUSE OF DEATH</p>		<p>33. MANNER OF DEATH</p>		<p>34. SIGNATURE OF REGISTRAR</p>		<p>35. SIGNATURE OF WITNESS</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. NAME OF DECEASED</p>		<p>38. SEX</p>		<p>39. AGE</p>		<p>40. DATE OF BIRTH</p>		<p>41. PLACE OF BIRTH</p>		<p>42. DATE OF DEATH</p>		<p>43. PLACE OF DEATH</p>		<p>44. CAUSE OF DEATH</p>		<p>45. MANNER OF DEATH</p>		<p>46. SIGNATURE OF REGISTRAR</p>		<p>47. SIGNATURE OF WITNESS</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. NAME OF DECEASED</p>		<p>50. SEX</p>		<p>51. AGE</p>		<p>52. DATE OF BIRTH</p>		<p>53. PLACE OF BIRTH</p>		<p>54. DATE OF DEATH</p>		<p>55. PLACE OF DEATH</p>		<p>56. CAUSE OF DEATH</p>		<p>57. MANNER OF DEATH</p>		<p>58. SIGNATURE OF REGISTRAR</p>		<p>59. SIGNATURE OF WITNESS</p>		<p>60. SIGNATURE OF DECEASED</p>	

BUREAU V. R.

NOV 14 1956

RECEIVED

1

11007

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10979
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY in 1b 63 Days				d. STREET ADDRESS 3396 Dulaney Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM E BORDEN				4. DATE OF DEATH Month Day Year November 1 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/20/94	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GRINDER		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Borden				14. MOTHER'S MAIDEN NAME Elizabeth Kline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I 212 07 5981		17. INFORMANT Address Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOMA OF RIGHT CORPUS COLLOSUM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 30, 1956 , to November 1, 1956 , and that death occurred at 6:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, Md. DATE SIGNED 11/2/56							
ACTUAL SIGNATURE C. J. Papastrat M.D.				PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-56		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Ave. Balto, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc.				24. REC'D BY REGISTRAR NOV 7 1956			
24b. REGISTRAR'S SIGNATURE Lawson L. Farber							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED John A. Smith		RESIDENCE 1234 Main Street, Baltimore, Md.	
DATE OF DEATH November 1, 1956		PLACE OF DEATH Home	
AGE 68 years		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION Retired		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		SIGNATURE OF PHYSICIAN J. H. Jones, M.D.	
DATE OF BURIAL November 3, 1956		PLACE OF BURIAL St. Mary's Cemetery	

BUREAU V. T.

NOV 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11008

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10980
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Penna. R.R. Tracks		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas d. STREET ADDRESS Beaver Dam Road near Texas Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY GAGLIANO BOSLEY First Middle Last		4. DATE OF DEATH November 9, 1956 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1916 9. AGE (In years last birthday) 40 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Gagliano	
14. MOTHER'S MAIDEN NAME Josephine Viola Gagliano		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Family records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing Injury of Skull (Crushed Beneath Railroad Train) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran into Side of Railroad Engine Pulled beneath wheels.	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles F. O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 12, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	22d. LOCATION (City, town, or county) (State) Texas, Balto. Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Son		ADDRESS Towson, Maryland	
24a. REC'D BY REGISTRAR NOV 14 1956		24b. REGISTRAR'S SIGNATURE Mabel Lewis	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Family History		Social History		Clinical History		Gross Findings	
Mental History		Physical Examination		Laboratory Findings		Microscopic Findings	
Autopsy		Toxicology		Histology		Immunology	
Pathology		Radiology		Cytology		Microbiology	
Immunology		Genetics		Pharmacology		Forensic Medicine	
Other		Other		Other		Other	

RECEIVED
 NOV 14 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 208 12-17-56 et

CERTIFICATE OF DEATH

10981

Reg. Dist. No. 30

11009

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 11mths9days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 211 F. Street Gateway/Nurs. Home-Hagerstown, Md.			
3. NAME OF DECEASED (Type or print) First Louis Middle I. Last Bowhay				4. DATE OF DEATH Month November Day 19 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1884	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Washington		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 02-006-0347		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 10, 1955 , to Nov. 19, 1956 , that I last saw the deceased alive on Nov. 19, 1956 , and that death occurred at 5:45a M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11-19-56			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-56		22c. NAME OF CEMETERY OR CREMATORY Moreland Park		22d. LOCATION (City, town, or county) (State) Balt Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Luck ADDRESS 530 E Harford				24a. REC'D BY REGISTRAR DATE 11-23-56		24b. REGISTRAR'S SIGNATURE Victor C. Harry	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11010

CERTIFICATE OF DEATH

Reg. Dist. No.

1098244

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 98 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2211 W. Saratoga Street			
3. NAME OF DECEASED (Type or print) First ISIAH Middle (NMI) Last BROOKS				4. DATE OF DEATH Month November Day 1 Year 19 56			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/08	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Ottoman, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Brooks				14. MOTHER'S MAIDEN NAME Sarah Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. 230 12 4011		17. INFORMANT Address Glin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKINS DISEASE DUE TO (b) 201x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 26 , 19 56 , to November 1 , 19 56 , that I last saw the deceased 12:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MD. DATE SIGNED 11/2/56							
ACTUAL SIGNATURE Irving Freeman M.D.				PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Acting Chief Medical Service			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 11/6/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles R. Law Mortuary 802-04 Madison Ave. Baltimore, Md.				24a. REC'D BY REGISTRAR NOV 7 1956		24b. REGISTRAR'S SIGNATURE Lawson L. Fuller	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11011

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mth 4dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		16-15-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 408 Greenlawn Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cecilia Middle Grace Last Brown		4. DATE OF DEATH Month November Day 19 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1886
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John R. Hanlon		14. MOTHER'S MAIDEN NAME Sarah Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pyelonephritis 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute urinary cystitis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 12, 1956 , to Nov. 19, 1956 , that I last saw the deceased alive on Nov. 19, 1956 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 11-19-56	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-23-56	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		24a. REC'D BY REGISTRAR 3821-14 St. NW	
24b. REGISTRAR'S SIGNATURE Victor C. Harry		DATE 11-23-56	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name and address.

RECEIVED

1956 3

BUREAU A. S.

10984

MARYLAND

STATE DEPARTMENT OF HEALTH

10982 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH- COUNTY <u>Lansdown Balto County</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto Co</u>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Lansdown</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>204 Hillsdale Ave</u>			
TOWN <u>Lansdown</u>				TOWN <u>204 Hillsdale Ave</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
		<u>Michael</u>		<u>G</u>		<u>Buckingham</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>II 26 36 19</u>	
8. DATE OF BIRTH <u>12-14-1870</u>		9. AGE last birthday <u>36</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Office Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Co</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>Ezra Buckingham</u>				14. MOTHER'S MAIDEN NAME <u>Lelena Gaylord</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>3m</u>				16. SOCIAL SECURITY No. <u>3m</u>			
17. INFORMANT AND ADDRESS <u>Mrs Lottie B Bucking 204 Hillsdale Ave</u>							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
161X Immediate cause (a) <u>Carcinoma of the larynx</u>						INTERVAL BETWEEN ONSET AND DEATH <u>approx 1 year</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>56</u> , to <u>Nov 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 26</u> , 19 <u>56</u> , and that death occurred at <u>2 30</u> p.m., from the causes and on the date stated above.							
SIGNATURE <u>Harbert J. Leiden</u>				ADDRESS <u>M.P. 2436 Washington Blvd Balto Md</u>		DATE SIGNED <u>11/27/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>II-29-56</u>		<u>Melville Cemetery</u>		<u>Elkridge Howard Co Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>11-28-56</u>		<u>L</u>		<u>Edward Toulson</u>		<u>2359 Wash Blvd Balto 30</u>	

MARGIN RESERVED FOR BINDING

25/8/11

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10983

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 918 Catawba Court				d. STREET ADDRESS 918 Catawba Ct.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BURNETT Middle Q. Last BURNOPP				4. DATE OF DEATH Month November Day 9 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1956		9. AGE (In years last birthday) yrs. 5	IF UNDER 1 YEAR Months 5 Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas W. Burnopp				14. MOTHER'S MAIDEN NAME Patricia D. Ries			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Thomas W. Burnopp 918 Catawba Court			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Otitis Media 391.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from, Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/9/56	
EXAMINER'S NAME (Type) William V. Lovitt, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/56		22c. NAME OF CEMETERY OR CREMATORY Our Lady of the Fields		22d. LOCATION (City, town, or county) (State) Millersville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Avenue		24a. REC'D BY REGISTRAR NOV 13 1956	
						24b. REGISTRAR'S SIGNATURE Geo. M. Zieffers	

2033182xvi

STATE OF MISSISSIPPI MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
 NOV 13 1956
 BUREAU V. S.

NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
DATE OF DEATH _____		PLACE OF DEATH _____	
TIME OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		SIGNATURE OF EXAMINER _____	
CITY _____		COUNTY _____	
STATE _____		ZIP CODE _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11012

CERTIFICATE OF DEATH

10986 30

Reg. Dist. No.

245

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7 mo 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				d. STREET ADDRESS 3705-40th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Homer Middle Kirk Last Butler				4. DATE OF DEATH Month November Day 10 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-25-89		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Marcellus Butler				14. MOTHER'S MAIDEN NAME Jane Ann Dean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give year or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital records, Spring Grove Hosp., Catonsville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of myocardium 420.1 DUE TO Arteriosclerotic Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Generalized Arteriosclerosis (c)						INTERVAL BETWEEN ONSET AND DEATH 10 min. 1 1/2 yrs. Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 29 , 19 56 , to Nov. 10 , 19 56 , that I last saw the deceased alive on Nov. 10 , 19 56 , and that death occurred at 11:40A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Louie Frances Woodward M.D.				ADDRESS (Street, city or town, state) Spring Grove State Hospital, Catonsville DATE SIGNED 11-10-56			
PHYSICIAN'S NAME (Type) Louie Frances Woodward, M. D.				Spring Grove State Hospital, Catonsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-13-56		22c. NAME OF CEMETERY OR CREMATORY mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home				ADDRESS mt. Rainier		24a. REC'D BY REGISTRAR Nov 12-56 24b. REGISTRAR'S SIGNATURE J. E. Harris	

BUREAU V. 1

1956 21 10

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

11013

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Hospital				d. STREET ADDRESS 2904 Baker St. Baltimore 16, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Campbell, Jr. Last Campbell, Jr.				4. DATE OF DEATH Month 11 Day 1 Year 1956			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 5 1905		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 50 Days 50	IF UNDER 24 HRS. Hours 50 Min. 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Ta		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Campbell sr.				14. MOTHER'S MAIDEN NAME Emley Chinn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 222-10-8436		17. INFORMANT Lucille Campbell Address 2904 Baker St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year NOV 19 1956 Hour 11 o. m. 11 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) M. B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		11-1-56	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-4-56		22c. NAME OF CEMETERY OR CREMATORY White Stone		22d. LOCATION (City, town, or county) (State) Ta	
23. FUNERAL DIRECTOR'S SIGNATURE Geo. S. Nelson				ADDRESS 1348 N. Calhoun St		24a. REC'D BY REGISTRAR Nov. 2, 1956	
				24b. REGISTRAR'S SIGNATURE Nelson L. Lasker			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR OF SKIN COLOR OF HAIR COLOR OF EYES COLOR OF TONGUE COLOR OF MUCOUS MEMBRANES COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM		DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR OF SKIN COLOR OF HAIR COLOR OF EYES COLOR OF TONGUE COLOR OF MUCOUS MEMBRANES COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM	
DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR OF SKIN COLOR OF HAIR COLOR OF EYES COLOR OF TONGUE COLOR OF MUCOUS MEMBRANES COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM		DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR OF SKIN COLOR OF HAIR COLOR OF EYES COLOR OF TONGUE COLOR OF MUCOUS MEMBRANES COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM	
DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR OF SKIN COLOR OF HAIR COLOR OF EYES COLOR OF TONGUE COLOR OF MUCOUS MEMBRANES COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM		DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR OF SKIN COLOR OF HAIR COLOR OF EYES COLOR OF TONGUE COLOR OF MUCOUS MEMBRANES COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM COLOR OF URINE COLOR OF STOOL COLOR OF SWEAT COLOR OF SALIVA COLOR OF SPUTUM	
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RECEIVED

NOV 5 1956

BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10988

11014

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 400 Carolina Road				d. STREET ADDRESS 400 Carolina Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ZERA First CANNADAY Middle Last				4. DATE OF DEATH Month November Day 28 Year 1956 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1899	
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager of Office				10b. KIND OF BUSINESS OR INDUSTRY Finance Company		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Isaac T. Cannaday				14. MOTHER'S MAIDEN NAME Lucy Peters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Family Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Nov. 26, 1956 Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Brain atrophy 2. Generalized wasting				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 6 , 19 54 , to Nov 28 , 19 56 , that I last saw the deceased alive on Nov 27 , 19 56 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund F. Potter				ADDRESS (Street, city or town, state) 6 E. Reed St. Balt. Md.			
PHYSICIAN'S NAME (Type) Edmund F. Potter				DATE SIGNED Nov 28 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 30, 1956		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Parkville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Soro				ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR Mabel C. Gray	
24b. REGISTRAR'S SIGNATURE Mabel C. Gray				DATE Nov 28 1956			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

NOV 30 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10989

Reg. Dist. No. 30

110'5

1. PLACE OF DEATH a. COUNTY Baltimore <div style="text-align: center;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 633 Aldershot Road				d. STREET ADDRESS 633 Aldershot Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Childs				4. DATE OF DEATH Month Nov. Day 26 Year 56			
5. SEX Male		6. COLOR OR RACE Whitr		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 9, 1883	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Shirt factory</i>		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME <i>George Childs</i>				14. MOTHER'S MAIDEN NAME <i>Joe Graw</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No		17. INFORMANT Margaret Childs, 633 Aldershot Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (b) Coronary Thrombosis (c) Coronary Thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Geo S M Kieffer</i> EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial				22b. DATE THEREOF 11/29/56		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
22d. LOCATION (City, town, or county) (State) Balto. Md.							
23. FUNERAL DIRECTOR'S SIGNATURE <i>MacHartson</i>				24a. REC'D BY REGISTRAR 11-28-56		24b. REGISTRAR'S SIGNATURE <i>V.E. Harry</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED
NOV 22 1956
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registration prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10990

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 14</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenn L. Martin Co.</u>				d. STREET ADDRESS <u>3530 Woodring Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Chisholm</u>				4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1907</u>	9. AGE (in years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer Glenn L. Martin</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ripley, Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Chisholm</u>				14. MOTHER'S MAIDEN NAME <u>Belle White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>199-01-9086</u>		17. INFORMANT Address <u>Mrs. Mary Frances Chisholm, 3530 Woodring</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-21-56</u>	
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/26/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>Nov. 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

NOV 28 1956

RECEIVED

11017 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 608 North Bend Rd.				d. STREET ADDRESS 608 North Bend Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Fannie Middle Lavinia Last Clark				4. DATE OF DEATH Month Nov. Day 29 Year 1956			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875	9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Zacharias Jacobs				14. MOTHER'S MAIDEN NAME Mary Louise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Mary Frank, 608 North Bend Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Hypertension						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 1948, to Nov. 26 , 1956, that I last saw the deceased alive on Nov. 26 , 1956, and that death occurred at 6:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo J. Gaver M.D.				ADDRESS (Street, city or town, state) 1 Mallow Hill Ave., Balto. Md.			
DATE SIGNED 11/30/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1/56		22c. NAME OF CEMETERY OR CREMATORY Western Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witte				ADDRESS 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE 3 1956	
				24b. REGISTRAR'S SIGNATURE Mary J. E.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF CORONER		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF FUNERAL HOME	

BUREAU V. S.

DEC 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11018 CERTIFICATE OF DEATH

10992

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 890 E. Joppa Road				d. STREET ADDRESS 830 E. Joppa Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JANE ELIZABETH CLARK				4. DATE OF DEATH Month Day Year November 11, 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1913		9. AGE (In years less birthday) yrs. 42	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George L. Gaines				14. MOTHER'S MAIDEN NAME Ida B. Boller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X uraemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ureteral obstruction DUE TO (c) carcinoma cervix uteri							INTERVAL BETWEEN ONSET AND DEATH 1 mo 3 mos 7 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April , 19 56 , to Nov 11 , 19 56 , that I last saw the deceased alive on Oct 23 , 19 56 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gerald A. Galvin				ADDRESS (Street, city or town, state) 1137 N. Monument St Baltimore MD		DATE SIGNED 11/12/56	
PHYSICIAN'S NAME (Type) GERALD A. GALVIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 13, 1956		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Parkville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burne Lons				ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR 11/13/56	
				24b. REGISTRAR'S SIGNATURE Mabel C. Gray			

[illegible]

BUREAU V. S.

NOV 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11019 CERTIFICATE OF DEATH

Reg. Di. 10993 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 44 Days		d. STREET ADDRESS 449 E. 28th Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ERIC D. CLAYTON First (Downtown) Last		4. DATE OF DEATH November 15 Month Day Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1907
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer		10b. KIND OF BUSINESS OR INDUSTRY Service Photo Supply Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Clayton		14. MOTHER'S MAIDEN NAME Emma Heiss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 214-01-2444	
17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF THE TONGUE WITH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 141X (c) XXXX DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m. VA	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 2 , 19 56 , to Nov. 15 , 19 56 and that death occurred at 1:26 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 11/15/56			
ACTUAL SIGNATURE R. D. Ponce de Leon M.D. VAH, FORT HOWARD, MARYLAND 11/15/56			
PHYSICIAN'S NAME (Type) R. D. PONCE DE LEON, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/19/56	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Tickner & Sons, North and Penna. Ave. Balto. Md. ADDRESS			
24a. REC'D BY REGISTRAR. 19 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Larkins	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10994

11020 CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b 49 Yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		d. STREET ADDRESS 204 Church Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Church Lane		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Corbin Middle Carroll Last Cogswell		4. DATE OF DEATH Month Nov , Day 7 , Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY General Builder	
11. BIRTHPLACE (State or foreign country) Wash, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles F. Cogswell		14. MOTHER'S MAIDEN NAME Emily Rawlings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-10-3298	
17. INFORMANT William J. Cogswell, Pikesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) myocardial infarction, acute DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1948, to 7 Nov , 1956, that I last saw the deceased alive on Oct 22, 1956 , and that death occurred at 11:52 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Paul H. Royse M.D. 8 Nov 56 PHYSICIAN'S NAME (Type) PAUL H ROYSE MD Pikesville Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-56	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) _____ (State) _____ Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell - Pikesville, Md.		24a. REC'D BY REGISTRAR DATE NOV 13 1956	
24b. REGISTRAR'S SIGNATURE Dorothy Newell			

BUREAU A.

NOV 13 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10995

10968 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK 22</u>		LENGTH OF STAY (In this place) <u>28 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK 22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11 FLAGSHIP ROAD</u>				STREET ADDRESS (If rural give location) <u>11 FLAGSHIP ROAD</u>			
3. NAME OF DECEASED (Type or Print) <u>HATTIE</u> (First) <u>HARDY</u> (Middle) <u>COLEMAN</u> (Last)				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>7</u> (Year) <u>1952</u>			
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT. 24, 1889</u>	9. AGE last birthday <u>67</u> Yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>G. W. HARDY 213-07-4900 B.</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET W. HARDY TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Ank.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NAME</u>		17. INFORMANT & ADDRESS <u>B. D. COLEMAN - SAME ADDRESS</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>15 min</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10</u> to <u>11-9</u>, 19<u>52</u>, that I last saw the deceased alive on <u>11-2</u>, 19<u>52</u>, and that death occurred at <u>6:50 P.</u>M. from the causes and on the date stated above.							
SIGNATURE <u>Carl Collins, A</u>		DATE THEREOF <u>11-10-56</u>		NAME OF CEMETERY OR CREMATORY <u>DAK LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bentley Moody, Dundalk, Md.</u>		DATE SIGNED <u>11-9-52</u>	
DATE <u>NOV 13 1956</u>		REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>		ADDRESS			

1956

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

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BUREAU V. 3

NOV 13 1956

RECEIVED

NOTARY PUBLIC

NOTARY PUBLIC
I, _____, Notary Public for the State of Maryland, do hereby certify that the foregoing is a true and correct copy of the original Certificate of Death filed in my office on this _____ day of _____, 19____.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

KNOWN Cardiac - J. H. Hagg.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10996
11021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										40
Item 13, Film G207, 12/4/56 bh										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White MARSH			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) white marsh					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Red lion					d. STREET ADDRESS Red lion			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Joseph Middle A. Last Couplin					4. DATE OF DEATH Month 11 Day 26 Year 1956					
5. SEX M		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-3-1883		9. AGE (In years last birthday) 73 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Couplin					14. MOTHER'S MAIDEN NAME Elizabeth Gram					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Elizabeth Couplin - some						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. 422.1 DUE TO Myocardial Degeneration Severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Advanced Atherosclerotic Cardiovascular Dis. Underl. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema, severe & INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs.										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE John C. Hyle					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED
EXAMINER'S NAME (Type) JOHN C. Hyle					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					11-27-56
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-56		22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery			22d. LOCATION (City, town, or county) (State) Loreley, Balto. Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Frances A. Hensley					ADDRESS Bidder St.		24a. REC'D BY REGISTRAR DATE 9 1956		24b. REGISTRAR'S SIGNATURE Dr. Walter Hammett	

RECEIVED

NOV 29 1956

BUREAU V. 5

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: *Robert H. Moore*
AGE: *40*
SEX: *M*
RACE: *W*
DATE OF DEATH: *10-21-56*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Myocardial Infarction*
MANNER OF DEATH: *Natural*
SIGNATURE OF EXAMINER: *[Signature]*
DATE OF EXAMINATION: *10-21-56*

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10997

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore County 3004 Duboise Ave Parkville Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 3004 Duboise Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rosalie Middle Cremona Last Cremona		4. DATE OF DEATH Month November Day 28 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11 1867
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Palermo-Sicily-Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Rosario Di Chiara		14. MOTHER'S MAIDEN NAME Vita Romano	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Gilda Cremona		Address 3004 Duboise Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hr May yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1956 , to November, 1956 , that I last saw the deceased alive on Nov. 28, 1956 , and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore Md. DATE SIGNED Nov. 29, 1956			
ACTUAL SIGNATURE S.E. Harris		M.D. 800 Maryland Rd., Baltimore, Md.	
PHYSICIAN'S NAME (Type) S.E. Harris			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1st 1956	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Noce		ADDRESS 322 S. High St.	
24a. REC'D BY REGISTRAR DEC 3 1956		24b. REGISTRAR'S SIGNATURE Dr. M. Bacon	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Age 21

Name of Deceased		Sex		Race		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Registrar		Signature of Physician	
JAMES EARL RAY		Male		White		November 10, 1928		Memphis, Tennessee		November 10, 1968		Memphis, Tennessee		Shot - Gun		Suicide		[Signature]		[Signature]	
Occupation		Education		Marital Status		Date of Marriage		Date of Last Contact		Date of Last Contact		Date of Last Contact		Date of Last Contact		Date of Last Contact		Date of Last Contact		Date of Last Contact	
None		High School		Single		None		None		None		None		None		None		None		None	
Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Registrar		Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Jury		Signature of Judge		Signature of Jury	
November 10, 1968		Memphis, Tennessee		Shot - Gun		Suicide		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 5

DEC 3 1968

RECEIVED

11023 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1815 Colonial Road		d. STREET ADDRESS 1815 Colonial Rd	
3. NAME OF DECEASED (Type or print) Caroline K. Crichton		4. DATE OF DEATH Month Nov. Day 5 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1869
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months 8 Days 7 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Kahler		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 414.14.1368A	
17. INFORMANT John P. Crichton		Address 1815 Colonial Rd. 7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Disease DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1947 to Mar. 5, 1956 that I last saw the deceased alive on Mar. 4, 1956 , and that death occurred at 11:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Morris W. Steinberg M.D.			
PHYSICIAN'S NAME (Type) MORRIS W. STEINBERG			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/8/56	22c. NAME OF CEMETERY OR CREMATORY Lorraine	22d. LOCATION (City, town, or county) (State) Woodlawn Md.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		ADDRESS 6411 Windsor Mill Rd	
24a. REC'D BY REGISTRAR NOV 7 1956		24b. REGISTRAR'S SIGNATURE Dr. J. E. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11024 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10999 28
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shepherdstown d. STREET ADDRESS 852-3	
3. NAME OF DECEASED (Type or print) First SERENA Middle KATHERINE Last DANDRIDGE		4. DATE OF DEATH Month November Day 7 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1877
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 19	IF UNDER 24 HRS. Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam S. Dandridge		14. MOTHER'S MAIDEN NAME Caroline D. Bedinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia secondary to Strangulation 974x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self	
20c. TIME OF INJURY Month, Day, Year 11/7 1956 Hour 2:30 a. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/7/56	
22c. NAME OF CEMETERY OR CREMATORY Shepherdstown, W. Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balt 17, Md.		24a. RECEIVED BY REGISTRAR Nov. 8, 1956	
24b. REGISTRAR'S SIGNATURE Mabel Gray		DATE	

DATE SIGNED

11/7/56

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death		Cause of Death		Manner of Death	
John Doe		Male		45		White		March 15, 1956		Home		Heart Disease		Natural	
Residence		Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Physician's Name		Hospital Name	
123 Main St.		Teacher		High School		Married		Hypertension		March 10, 1956		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Deceased		Signature of Family		Signature of Witness		Signature of Burial	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

NOV 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11025 CERTIFICATE OF DEATH

11000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 341 Nicholson Ave.		d. STREET ADDRESS 341 Nicholson Ave.,	
3. NAME OF DECEASED (Type or print) First JOHN Middle DANINI Last		4. DATE OF DEATH Month NOV. Day 2ND Year 1986	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13/81
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Worker		10b. KIND OF BUSINESS OR INDUSTRY Cement Business	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Danini		14. MOTHER'S MAIDEN NAME Celeste Cerri	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-05-1276	
17. INFORMANT Mrs. Caroline Danini		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tumor, anterior mediastinum, Teratoma DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 14 , 19 86 , to Nov. 2 , 19 86 , that I last saw the deceased alive on Nov. 2 , 19 86 , and that death occurred at 9:00p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8019 Philadelphia Rd. Balt. 6, Md. 11-5-86			
ACTUAL SIGNATURE James R. Mason M.D.		PHYSICIAN'S NAME (Type) James R. Mason, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6th, 86	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Belair Road Balto, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly		ADDRESS Essex, Md.	
24a. REC'D BY REGISTRAR NOV 8 1986		24b. REGISTRAR'S SIGNATURE Edith Hurley	

RECEIVED

11026

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>605 Railroad Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Imogene</u> Middle <u>DAVID</u> Last <u>DAVID</u>				4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/49</u>		9. AGE (In years last birthday) <u>6</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>28</u> Hours <u>1956</u>	IF UNDER 24 HRS. Hours <u>1956</u> Min. <u>1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles David</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address <u>Mrs. Mary Bailey Nock (Mother) 605 Railroad Ave. Salisbury, Md.</u> <u>Rosewood Records, Owings Mills, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute bronchitis</u> DUE TO (c) <u>Arnold Chiari Syndrome</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>since birth</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 7, 1953</u> to <u>Nov. 28, 1956</u> , that I last saw the deceased alive on <u>Nov. 28, 1956</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Owings Mills, Maryland.</u> <u>11/29/56</u>							
ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D. <u>Owings Mills, Maryland.</u>				DATE SIGNED <u>11/29/56</u>			
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 3, 1956</u>		<u>Riverside Cemetery</u>		<u>Near Berlin, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 3 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elsie</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU A. 5.

DEC 3 1956

RECEIVED

11002 11002 Reg. Dist. No. 44 11027 CERTIFICATE OF DEATH 11002 Reg. Dist. No. 44

11027

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIE Middle Y. Last DEROSSETT				4. DATE OF DEATH Month November Day 17 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/16/88	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Box Factory		11. BIRTHPLACE (State or foreign country) Nashville, Tennessee	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Derossett				14. MOTHER'S MAIDEN NAME Lilly Hudgins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW I				16. SOCIAL SECURITY NO. 235-10-9627		17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA 332x DUE TO CEREBRAL THROMBOSIS, RIGHT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Arteriosclerotic heart disease. 2. Uremia 3. Uremic colitis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 16 1956 to November 17, 1956 and that death occurred at 10:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 11/19/56							
ACTUAL SIGNATURE C. J. Papastrat M.D.							
PHYSICIAN'S NAME (Type) C. J. PAPAISTRAT, M.D., VA HOSPITAL, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 11-19-56		22c. NAME OF CEMETERY OR CREMATORY Roderfield Cemetery	
22d. LOCATION (City, town, or county) (State) Roderfield, W. Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight Inc.				24a. REC'D BY REGISTRAR 11-23-56		24b. REGISTRAR'S SIGNATURE Dr. Dawson L. Farber	
ADDRESS 6009 Harford Rd., Balto. 14, Md							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Shipped to O.J. Douglas Funeral Home, Welch, W. Virginia

CERTIFICATE OF DEATH

Name of Deceased		John Deaton	
Sex		Male	
Age		35	
Date of Birth		1915	
Place of Birth		Maryland	
Occupation		Laborer	
Cause of Death		Heart Failure	
Date of Death		1955	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU A. 1

NOV 23 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1100344

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SPARROWS POINT		c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10				d. STREET ADDRESS 1912 NEVILL RD.			
3. NAME OF DECEASED (Type or print) First GEORGE Middle * Last DIETER				4. DATE OF DEATH Month 11 Day 8 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		10b. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL		11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN DIETER				14. MOTHER'S MAIDEN NAME UNK.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-07-8066		17. INFORMANT GEORGE E. DIETER Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 10 min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Jack C. Collins</i> EXAMINER'S NAME (Type) JACK C. COLLINS				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 11-12-56		22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	
23. FUNERAL DIRECTOR'S SIGNATURE DUNDALK 22, MD.				22d. LOCATION (City, town, or county) BALTIMORE CO. MARYLAND		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE <i>Harmon L. Farber</i>		DATE SIGNED 11-8-56	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NOV 13 1956

MASSACHUSETTS DEPARTMENT OF HEALTH—BAYLOR

BUREAU V. S.

NOV 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11004

11029

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1216 W. Fayette Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DANIEL Middle E. Last DIXON, SR				4. DATE OF DEATH Month November Day 16 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 5, 1899	
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Buildings		11. BIRTHPLACE (State or foreign country) Unionville, Maryland	
12. CITIZEN OF WHAT COUNTRY? US. A.							
13. FATHER'S NAME George Bates Dixon				14. MOTHER'S MAIDEN NAME Addie Hammond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 215-01-1921		17. INFORMANT Address Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TUBERCULOUS PERICARDITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 15, 1956 to November 16, 1956 and that death occurred at 3:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 11/16/56 ACTUAL SIGNATURE C. M. SNYDER, M. D. PHYSICIAN'S NAME (Type) C. M. SNYDER, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 20, '56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George H. Hoiland				24a. REC'D BY REGISTRAR Nov. 19, 1956			
24b. REGISTRAR'S SIGNATURE Dawson L. Fairley							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Place of Death	
John Doe		Male		45		Jan 1, 1900		New York City		Natural		Heart Disease		Home	
Occupation		Education		Marital Status		Date of Marriage		Date of Death		Time of Death		Physician		Hospital	
Teacher		High School		Married		Jan 1, 1920		Jan 15, 1945		10:00 AM		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Undertaker		Signature of Burial Officer		Signature of Cemetery	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Jan 15, 1945		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Date of Burial		Time of Burial		Place of Burial		Cause of Burial		Manner of Burial		Signature of Burial Officer		Signature of Cemetery		Signature of Undertaker	
Jan 18, 1945		12:00 PM		St. Mary's		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	

Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
Jan 15, 1945		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	

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JAN 20 1956

BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11005

11030 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 713 Walker Ave.				d. STREET ADDRESS 713 Walker Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle C. Last DORSEY				4. DATE OF DEATH Month Nov. Day 12 Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1878		9. AGE (In years last birthday) 88 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Augustus Litsinger				14. MOTHER'S MAIDEN NAME Margaret Fishpaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Carroll Bruehl - 713 Walker Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Renal DUE TO (c) Vascular Disease						INTERVAL BETWEEN ONSET AND DEATH 48 Hrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 9, 1950 , to Nov 12, 1956 , that I last saw the deceased alive on Nov 12, 1956 , and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				ADDRESS (Street, city or town, state) 7501 York Rd. Baltimore 12			
PHYSICIAN'S NAME (Type) Charles F. O'Donnell				DATE SIGNED Nov 14, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. J. Pickner & Sons - Balto. 17, Md.				24a. REC'D BY REGISTRAR DATE Nov 14, 1956		24b. REGISTRAR'S SIGNATURE Walter Gray	

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NOV 15 1956

BUREAU V. 2

11000 CERTIFICATE OF DEATH		11000	
STATE OF MARYLAND		DEPARTMENT OF HEALTH - BALTIMORE, MD	
NAME OF DECEASED		DATE OF DEATH	
AGE		SEX	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	
PLACE		PLACE	
COUNTY		COUNTY	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
FEDERAL ID NUMBER		FEDERAL ID NUMBER	
MAYOR'S SIGNATURE		MAYOR'S SIGNATURE	
DATE		DATE	
PLACE		PLACE	
COUNTY		COUNTY	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
FEDERAL ID NUMBER		FEDERAL ID NUMBER	

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3012 Acton Road</u>		d. STREET ADDRESS <u>3012 Acton Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mr. Joseph</u> Middle <u>J.</u> Last <u>Doyle</u>		4. DATE OF DEATH Month <u>November</u> Day <u>17th</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ireland</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Doyle</u>		14. MOTHER'S MAIDEN NAME <u>Helen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Elizabeth J. Doyle, 3012 Acton Road</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> <u>153x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9 am</u> , 19 <u>56</u> to <u>11/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/16/56</u> , and that death occurred at <u>7 pm</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Sol Smith</u> M.D. <u>1261 E Belvedere Ave</u>		<u>11/17/56</u>	
PHYSICIAN'S NAME (Type) <u>Sol Smith</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/20/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>Dr. R. M. Bacon</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	

11032 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Swy. Hall Baltimore 21, Md.</u>		d. STREET ADDRESS <u>2703 Orleans Street</u>	
3. NAME OF DECEASED (Type or print) <u>FANNIE</u> First Middle Last <u>DRESSEL</u>		4. DATE OF DEATH <u>Nov.</u> Month <u>19</u> Day <u>1956</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Siegel</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>John Dressel, husband, above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma uterus</u> DUE TO (c) <u>174X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/13, 1956</u> , to <u>11/19, 1956</u> , that I last saw the deceased alive on <u>11/19, 1956</u> , and that death occurred at <u>930</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. L. Kolodny, M.D.</u>		ADDRESS (Street, city or town, state) <u>1825 Eastern Blvd. Baltimore 21, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. L. KOLODNY, M.D.</u>		DATE SIGNED <u>11/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 23, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>Edith Hurley</u>	
ADDRESS <u>2601-3-5 E. Madison St.</u>		DATE <u>11-21-56</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 2 and 3 should be filed with the registrar.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION Minister	
7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 175		11. BUILD Slender		12. EDUCATION High School	
13. PRESENT ADDRESS 2001 E. Lombard St. Baltimore, Md.		14. DATE OF DEATH Apr 4, 1968		15. PLACE OF DEATH Baltimore, Md.		16. CAUSE OF DEATH Suicide		17. MANNER OF DEATH Homicide		18. MEDICAL HISTORY None	
19. SIGNATURE OF DECEASED (None)		20. SIGNATURE OF WITNESS (None)		21. SIGNATURE OF PHYSICIAN (None)		22. SIGNATURE OF CORONER (None)		23. SIGNATURE OF JURY (None)		24. SIGNATURE OF STATE DEPARTMENT OF HEALTH (None)	

BUREAU V. S.

NOV 21 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11008

11033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Manor Road		d. STREET ADDRESS Manor Rd.	
3. NAME OF DECEASED (Type or print) First PIERRE Middle CHATARD Last DUGAN		4. DATE OF DEATH Month November Day 19 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1912
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ferdinand Dugan	
14. MOTHER'S MAIDEN NAME Melanie Boone		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 314-3366436		17. INFORMANT Wife, Address Manor Rd., Balto. Co.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Shot self in head		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 11/19 19 56 Hour a. m. 1:30 White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Balto. Co.		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		DATE SIGNED 11/19/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/56	
22c. NAME OF CEMETERY OR CREMATORY Balto National		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart Mowbray		ADDRESS 108 W York - Balto	
24a. REC'D BY REGISTRAR Nov 20 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Sex		Male	
Age		35	
Date of Birth		Jan. 10, 1912	
Place of Birth		New York	
Usual Residence		New York	
Cause of Death		Gunshot wound of head	
Place of Death		New York	
Date of Death		Jan. 15, 1956	
Time of Death		1:10 PM	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	

RECEIVED
JAN 20 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11034 CERTIFICATE OF DEATH

11009

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Containsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 N. Symington Ave.				d. STREET ADDRESS 9 N. Symington Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle LEAH Last DUNWOODY				4. DATE OF DEATH Month Nov. Day 18, Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1871	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Josiah Geesaman				14. MOTHER'S MAIDEN NAME Annie Pentz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Miss Ruth Dunwoody - 9 N. Symington Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3 days 3 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Nov 16, 1956 to Nov 18, 1956 , that I last saw the deceased alive on Nov 16, 1956 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John A. Nesbitt, Jr. M.D. 1115 St Paul St		PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR. Baltimore 2, Ind					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/56		22c. NAME OF CEMETERY OR CREMATORY Harbaugh Cem.		22d. LOCATION (City, town, or county) (State) Franklin Co., Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Sienkiewicz & Sons - Balto 17 Ind				24a. REC'D BY REGISTRAR DATE Nov 20, 1956		24b. REGISTRAR'S SIGNATURE G. E. Barry	

21 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,9 Film G206 11-13-56 et

CERTIFICATE OF DEATH

11010

Reg. Dist. No.

11035

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Essex)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "Ivy Hall" 19 Harrison Ave.				d. STREET ADDRESS 1720 Middleborough 19 Harrison Ave			
3. NAME OF DECEASED (Type or print) First Hilda Middle L Last Elder				4. DATE OF DEATH Month Nov Day 2 Year 19 56			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Approx. 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 58	
11. BIRTHPLACE (State or foreign country) Chicago, Illinois				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. Samuel Elder, 1720 Middleborough				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 431X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Toxic myocarditis (c) Septicemia						INTERVAL BETWEEN ONSET AND DEATH 1 day 3 mo. 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bleeds Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 11/2 , 19 56 , to 11/2 , 19 56 , that I last saw the deceased alive on 11/1 , 19 56 , and that death occurred at 2 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Blatt				ADDRESS (Street, city or town, state) 434 Eastern Ave. Essex, Md			
DATE SIGNED 11/2/56				DATE SIGNED			
PHYSICIAN'S NAME (Type) Dr J J Platt				ADDRESS 434 Eastern Ave Baltimore-21, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/56		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Hartford Road #14		24a. REC'D BY REGISTRAR 1956	
24b. REGISTRAR'S SIGNATURE Edith H. H. H.				DATE 1956			

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10969 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11012

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE 22</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 22</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>104 Walnut Ave., Turner Station, Md.</u>				d. STREET ADDRESS <u>104 WALNUT AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SALLIE</u> First <u>ANN</u> Middle <u>FALDEN</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/4/1906</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Terrell</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Terrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Theodore Falden - 104 Walnut St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE CARDIOVASCULAR</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>RENAL DISEASE</u> (a), stating the underlying cause lost. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>44YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ME. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>				ADDRESS <u>802 Madison Avenue</u>		24a. REC'D BY REGISTRAR <u>NOV 28 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mr. Kelly</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11037 CERTIFICATE OF DEATH

Reg. Dist. No.

110130

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 4905 SHERIDAN ST.	
3. NAME OF DECEASED (Type or print) LULA MARY FAULKNER		4. DATE OF DEATH NOVEMBER 3 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1. 1. 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CORNELIUS KISEN		14. MOTHER'S MAIDEN NAME MARTHA WINDELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 493X (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETIS MELLITUS - GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 2 , 19 55 , to Nov. 3 , 19 55 , that I last saw the deceased alive on Nov. 3 , 19 55 , and that death occurred at 2 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler M.D.		ADDRESS (Street, city or town, state) Spring Grove St. Hospital	
PHYSICIAN'S NAME (Type) STELLA WACHSLER		DATE SIGNED Catonville 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-6-56	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Bladensburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. W. Chambers, Wash DC		24. REGISTRAR'S SIGNATURE Nov 7 1956	

CERTIFICATE OF DEATH

Top Box No.

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1900</i></p>		<p>5. PLACE OF BIRTH <i>Baltimore, Md</i></p>	
<p>6. OCCUPATION <i>Teacher</i></p>		<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. DATE OF DEATH <i>Nov 10 1945</i></p>		<p>10. PLACE OF DEATH <i>Home</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>12. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>13. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>14. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>15. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>16. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>17. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>18. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>19. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>20. SIGNATURE OF DECEASED <i>John Doe</i></p>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11038 CERTIFICATE OF DEATH

Reg. Dist. No. 11014 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 8 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1976 West Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ARTHUR Middle (NMI) Last FISHER				4. DATE OF DEATH Month November Day 13 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 30, 1892	
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Moving - Hauling		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Solomon Fisher				14. MOTHER'S MAIDEN NAME Pricilla Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> WW I				16. SOCIAL SECURITY NO. 214-05-2535		17. INFORMANT Address Clinical Records, VA Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 YEARS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from November 5, 1956 to November 13, 1956 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C. J. Papastrat				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND		DATE SIGNED 11/14/56	
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Fowlers Chapel Church		22d. LOCATION (City, town, or county) (State) Beth Gate, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Reese Funeral Home, 108 Washington St., Annapolis, Maryland				24a. REC'D BY REGISTRAR Nov. 20, 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11039

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 12 FilmG207 12-3-56 et

11015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS PT 19</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 22; DUNDALK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fisher Rd</u>		d. STREET ADDRESS <u>1950 Searles Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Desmond</u> Middle <u>Dionigio</u> Last <u>Forti</u>		4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 31, 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRANE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel, BETHLEHEM</u>	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROMULDO FORTI</u>		14. MOTHER'S MAIDEN NAME <u>AGNES POSTAL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>URBAN FORTI</u>		Address <u>MT. CARMEL, PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound - Chest</u> 976x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted gunshot wound (22 cal.) chest</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 11-28-56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Seiler</u>		ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>	
24a. REC'D BY REGISTRAR <u>Nov 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Larkins</u>	

BUREAU V. S.

NOV 28 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11040

11016

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penn. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lovely		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phila.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fulaski Highway		d. STREET ADDRESS 1744 N. 15th St.	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle FOSTER Last		4. DATE OF DEATH Month Nov. Day 26, Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> separated WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/1929
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Charolette, N.C.
13. FATHER'S NAME David Foster		14. MOTHER'S MAIDEN NAME Cleora Dawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes Korean		16. SOCIAL SECURITY NO.	
17. INFORMANT Cleora Dawkins		Address 1923 Ridgehill Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury of chest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 816X DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-truck collision	
20c. TIME OF INJURY Month, Day, Year 11/25/ 19 56 Hour, minute 11:30 P. M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) Balto. (County) Md. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) Anne Arundel Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Randolph J. Collick		ADDRESS 1412 E. Preston St.	
24a. REC'D. BY REGISTRAR Dec 3, 1956		24b. REGISTRAR'S SIGNATURE Dr. Walter Hammett	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
11013 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		David Foster	
Sex		Male	
Race		Colored	
Date of Birth		5/1/1929	
Place of Birth		Charlotte, N.C.	
Usual Residence		Gloria Hawkins 1923 Kilmorrell Ave.	
Cause of Death		Cerebral injury of chest	
Manner of Death		Auto-truck collision	
Date of Death		11/30/56	
Place of Death		Street	
Signature of Physician		William V. Lovitt, Jr., M.D.	
Signature of Medical Examiner		H. C. Gentry, Secretary	
Signature of Coroner		H. C. Gentry, Coroner	
Signature of Burial Director		H. C. Gentry, Burial Director	

BUREAU V. B.

DEC 4 1956

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BALTIMORE
NOV 11 1956
H. C. Gentry, Secretary
H. C. Gentry, Coroner
H. C. Gentry, Burial Director

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11017

11041

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 Wayne Nursing Home, 98 Smith Wood Ave				d. STREET ADDRESS 13 Holmehurst Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jacob Middle N. Foster Last				4. DATE OF DEATH Month Nov. Day 1 Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 5, 1870	
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY General Electric Co. Balto. Md.			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Foster				14. MOTHER'S MAIDEN NAME Hannah Vance			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address Mrs Earl Smallwood, 13 Holmehurst Ave							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic Heart Disease DUE TO with Hyper Tension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arterio Sclerosis DUE TO 5 years (c)							INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from MAY 3 , 19 48 , to November 1, 1956 , that I last saw the deceased alive on October 30, 1956 , and that death occurred at 6:35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Melvin N. Borden M.D.				ADDRESS (Street, city or town, state) 5000 OLD FREDERICK RD BALTIMORE 29, MD.			
DATE SIGNED 11/2/56							
PHYSICIAN'S NAME (Type) McLVIN N. BORDEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 3/56		22c. NAME OF CEMETERY OR CREMATORY Louden Park		22d. LOCATION (City, town, or county) (State) Balto Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry A. Witzke ADDRESS 4101 Edmondson Ave							
24a. REG'D BY REGISTRAR NOV 7 1956				24b. REGISTRAR'S SIGNATURE J. E. Lany			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APRIL 14, 1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MAY 2, 1968		BALTIMORE, MARYLAND		HEART DISEASE	
OCCUPATION		EDUCATION		MARRIAGE	
CONTRACTOR		HIGH SCHOOL		MARRIED	
PREVIOUS ILLNESS		HABIT		RELIGION	
NONE		SMOKER		METHODIST	
DATE OF LAST PHYSICIAN VISIT		NAME OF PHYSICIAN		HOSPITAL	
MAY 1, 1968		DR. J. H. HARRIS		BALTIMORE HOSPITAL	
DATE OF LAST HOSPITAL ADMISSION		NAME OF HOSPITAL		PHYSICIAN IN CHARGE	
MAY 1, 1968		BALTIMORE HOSPITAL		DR. J. H. HARRIS	
DATE OF LAST HOME VISIT		NAME OF HOME VISITOR		HOSPITAL	
MAY 1, 1968		DR. J. H. HARRIS		BALTIMORE HOSPITAL	

SIGNATURE OF DECEASED		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES EARL RAY		DR. J. H. HARRIS		J. H. HARRIS	
DATE		DATE		DATE	
MAY 2, 1968		MAY 2, 1968		MAY 2, 1968	
PLACE		PLACE		PLACE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
OCCUPATION		OCCUPATION		OCCUPATION	
CONTRACTOR		CONTRACTOR		CONTRACTOR	
EDUCATION		EDUCATION		EDUCATION	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
MARRIAGE		MARRIAGE		MARRIAGE	
MARRIED		MARRIED		MARRIED	
RELIGION		RELIGION		RELIGION	
METHODIST		METHODIST		METHODIST	

RECEIVED
 NOV 7 1956
 BUREAU V. 1

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APRIL 14, 1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MAY 2, 1968		BALTIMORE, MARYLAND		HEART DISEASE	
OCCUPATION		EDUCATION		MARRIAGE	
CONTRACTOR		HIGH SCHOOL		MARRIED	
PREVIOUS ILLNESS		HABIT		RELIGION	
NONE		SMOKER		METHODIST	
DATE OF LAST PHYSICIAN VISIT		NAME OF PHYSICIAN		HOSPITAL	
MAY 1, 1968		DR. J. H. HARRIS		BALTIMORE HOSPITAL	
DATE OF LAST HOSPITAL ADMISSION		NAME OF HOSPITAL		PHYSICIAN IN CHARGE	
MAY 1, 1968		BALTIMORE HOSPITAL		DR. J. H. HARRIS	
DATE OF LAST HOME VISIT		NAME OF HOME VISITOR		HOSPITAL	
MAY 1, 1968		DR. J. H. HARRIS		BALTIMORE HOSPITAL	

11042 CERTIFICATE OF DEATH

11018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 2 mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) SHARBY NOOK NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah A. Fritz		4. DATE OF DEATH Nov 29 1956	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCT 19-1866
9. AGE (In years last birthday) 90		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Charles H. Fritz		Address 1301 HINDEN AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ?			INTERVAL BETWEEN ONSET AND DEATH approx 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct , 1956, to Nov 29 , 1956, that I last saw the deceased alive on Nov 19 , 1956, and that death occurred at 5:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert J. Levickas M.D.		ADDRESS (Street, city or town, state) 2436 Washington Blvd Baltimore - 30, Md.	
PHYSICIAN'S NAME (Type) Herbert J. Levickas		DATE SIGNED 11/30/56	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF DEC 3-1956	22c. NAME OF CEMETERY OR CREMATORY HOUSON PARK	22d. LOCATION (City, town, or county) (State) BALTO MD
23. FUNERAL DIRECTOR'S SIGNATURE Edward Toulson		24a. REC'D BY REGISTRAR DEC 3 1956	24b. REGISTRAR'S SIGNATURE P. E. HARRIS

BUREAU V. S.

DEC 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1097 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12140

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b about 20 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2972 Cornwall Rd.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 2972 Cornwall Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hattie (Hedwig) Funk				4. DATE OF DEATH Month Day Year November 30, 19 56			
5. SEX F		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 1, 1902	
9. AGE (In years last birthday) 54 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Lena Darr 21 E.D. Brunswick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis		EXAMINER'S NAME (Type) M. B. DAVIS M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/4/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Dec. 5, 1956		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ullrich Funeral Home 4210 Belair Rd. Balto.				24a. REC'D BY REGISTRAR DEC 7 1956		24b. REGISTRAR'S SIGNATURE Wm. P. Kelly	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11043

CERTIFICATE OF DEATH

Reg. Dist. No. 11019

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>119 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS G GALANTE</u>				4. DATE OF DEATH Month Day Year <u>November 25 19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/19/26</u>	
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Repairman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>CORINO</u>				14. MOTHER'S MAIDEN NAME <u>SPLENDORA PALOME</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>WWII</u>				16. SOCIAL SECURITY NO. <u>215-20-0075</u>		17. INFORMANT Address <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NEURO SARCOMA</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>VON RECKBURGHUSEN'S DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 29</u> , 19 <u>56</u> , to <u>November 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/25/56</u> , and that death occurred at <u>5:20A</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Veterans Administration Hospital</u> DATE SIGNED <u>11/25/56</u> ACTUAL SIGNATURE <u>Constantine J. Papastrat</u> M.D. PHYSICIAN'S NAME (Type) <u>CONSTANTINE J. PAPASTRAT, M.D. Fort Howard, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>11/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bridgeville Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Bridgeville, Delaware</u>				22e. (State) <u>Delaware</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>HARDESTY FUNERAL HOME, BRIDGEVILLE, DELAWARE</u>				24a. REC'D BY REGISTRAR <u>NOV 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. L. L.</u>	

MEDICAL CERTIFICATION

RECEIVED

11044 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 105 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle A. Last GILLINGHAM		4. DATE OF DEATH Month November Day 10 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3/13
9. AGE (In years lost birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembly Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Copper Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William G. Gillingham		14. MOTHER'S MAIDEN NAME Minnie Forbinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> WWII		16. SOCIAL SECURITY NO. 213-20-3450	
17. INFORMANT Clin. Rec. Vets. Admin. Hospital. Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Meningitis, post operative 2. Urinary bladder stones			INTERVAL BETWEEN ONSET AND DEATH Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 28 , 19 56 , to November 10 , 19 56 , and that death occurred at 9:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Constantine J. Papastrat, M.D. Veterans Administration Hospital 11/10/56			
PHYSICIAN'S NAME (Type) CONSTANTINE J. PAPASTRAT, M.D. Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-56	22c. NAME OF CEMETERY OR CREMATORY Baltimore National
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.		24a. REC'D BY REGISTRAR Nov 15, 1956	24b. REGISTRAR'S SIGNATURE Lawson L. Garber
ADDRESS Wm Cook-Blight Funeral Home, Inc. 6009 Harford Rd. Baltimore, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
John Doe		45		Male		White		1910		Maryland	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
1955		10:00 AM		Home		Heart Disease		Natural		Coronary Artery Disease	
DATE OF REPORT		TIME OF REPORT		PLACE OF REPORT		REPORTED BY		RELATIONSHIP		SIGNATURE	
1955		11:00 AM		Home		John Doe		Son		[Signature]	
DATE OF INTERVIEW		TIME OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWED BY		RELATIONSHIP		SIGNATURE	
1955		12:00 PM		Home		John Doe		Son		[Signature]	
DATE OF REVIEW		TIME OF REVIEW		PLACE OF REVIEW		REVIEWED BY		RELATIONSHIP		SIGNATURE	
1955		1:00 PM		Home		John Doe		Son		[Signature]	

RECEIVED
NOV 16 1956
BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11021

10984 CERTIFICATE OF DEATH

Reg. Dist. No.

4r

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b 20 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1208 Francis Ave.		d. STREET ADDRESS 1208 Francis Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lambert Rumsey Gittings		4. DATE OF DEATH Month Day Year November 7, 1956 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Used Car		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John R. Gittings		14. MOTHER'S MAIDEN NAME Emma Clarey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John A. Gittings		Address 1208 Francis Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) Myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 277			
INTERVAL BETWEEN ONSET AND DEATH 1 day			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May, 1934 , to Nov 8, 1956 , that I last saw the deceased alive on Nov 8, 1956 , and that death occurred at 4:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE B B Brumbaugh M.D. 5609 Myrtle St 27MD PHYSICIAN'S NAME (Type) B B Brumbaugh 11/8/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 10, 1956	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Amber Inc. 1328 Sulphur Sp. Rd.		24a. REC'D BY REGISTRAR DATE Nov. 8, 1956	
24b. REGISTRAR'S SIGNATURE Dr. Geo M. Huffer			

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November 7, 1956

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John H. Gillingham

John A. Williams 1808 Franklin Ave.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11022

Reg. Dist. No.

11045

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b 67 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 623 E St.		d. STREET ADDRESS 623 E. Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CATHERINE Middle W. Last GLADFELTER		4. DATE OF DEATH Month Nov. 11, Day 19 Year 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 11 Days 11 Hours 56	IF UNDER 24 HRS. Months 11 Days 11 Hours 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Penna	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Weir		14. MOTHER'S MAIDEN NAME Elizabeth Hess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Bertha Deardorff		Address 623 E. St. --19	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - Hypostatic 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis - Gen. DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH 1 wk 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1, 1956 , to Nov 11, 1956 , that I last saw the deceased alive on Nov 11, 1956 , and that death occurred at 10:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R G WILKINS		ADDRESS (Street, city or town, state) DATE SIGNED 520 D St. SpR 19 11.12	
PHYSICIAN'S NAME (Type) R G WILKINS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 14, 1956	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	22d. LOCATION (City, town, or county) (State) Colgate, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		ADDRESS 2112 Dundalk Ave.	
24a. READ BY REGISTRAR Nov. 15, 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Lantieri	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1956	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
BIRTH DATE		BIRTH PLACE	
JAN 15 1891		BALTIMORE, MD	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 15 1915		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
Physician		Burial Place	
J. H. Harris		Catholic Cemetery	
Signature of Physician		Signature of Registrar	
J. H. Harris		J. H. Harris	
Date of Signature		Date of Signature	
JAN 15 1956		JAN 15 1956	

BUREAU V. 8

JAN 15 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>5 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>305 Ingleside Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>				d. STREET ADDRESS <u>Catonsville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>B.</u> Last <u>Glaser</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1882</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Baker</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mrs. J.D. Collins 305 Ingleside Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crown Thrombosis</u> DUE TO (c) <u>Arterio Sclerosis general</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>24 hrs.</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Debility</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Nov 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>56</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 Edmonson Ave</u> DATE SIGNED <u>12/1/56</u>							
ACTUAL SIGNATURE <u>Cliff Ratliff Jr.</u> M.D. <u>4605 Edmonson Ave</u>							
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u> <u>4605 EDMONSON AVE.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>12-2-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Northwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Ohio</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tracy Funeral Home - Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 4 1956</u>		24b. REGISTRAR'S SIGNATURE <u>F. E. Harvey</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be filled in by the funeral director. Pages 4 and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

11047 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH o. COUNTY <i>Balto Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonoville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonoville md</i>	
c. LENGTH OF STAY IN 1b <i>life</i>		d. STREET ADDRESS <i>(Same)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <i>5510 Old Frederick Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Agnes Graber</i>		4. DATE OF DEATH <i>11/13/56</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 5, 1874</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles H. Graber</i>		14. MOTHER'S MAIDEN NAME <i>Sterner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Wm. V. Graber</i>		Address <i>(Same)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio sclerotic C-V Disease</i> DUE TO (c) <i>Senile Changes</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 mos</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/20</i> , 19 <i>55</i> , to <i>11/13</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11/13</i> , 19 <i>56</i> , and that death occurred at <i>7:00 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Victor F. Zing</i>		M.D. <i>Catonoville, Md</i>	
PHYSICIAN'S NAME (Type) <i>Macnab + Son</i>		DATE SIGNED <i>11/14/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/16/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	22d. LOCATION (City, town, or county) (State) <i>Balto md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Macnab + Son</i>		24a. REC'D BY REGISTRAR <i>28</i>	24b. REGISTRAR'S SIGNATURE <i>V.E. Harvey</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

NOV 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. 11048

CERTIFICATE OF DEATH

11025

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City (30) 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 1528 Clarkson St	
3. NAME OF DECEASED (Type or print) First Edward Middle Russel Last Gregory		4. DATE OF DEATH Month November Day 17 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-17-1888
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (SA)		10b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg.	
11. BIRTHPLACE (State or foreign country) Balt. City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur O. Gregory		14. MOTHER'S MAIDEN NAME Emma E. Glass	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or date of service) 215-05-4443	
17. INFORMANT Hospital records, Mt. Wilson State Hosp.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) far Advanced Pulmonary TB. DUE TO with a large cavity in it upper lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Partial heart block. Myocardial damage. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 46 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-13, 1956 , to 11-17, 1956 , that I last saw the deceased alive on 11-17, 1956 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 11-17-1956			
ACTUAL SIGNATURE William Newcomer M.D.		DATE SIGNED 11-17-1956	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Mt. Wilson, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 21-1956	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem	22d. LOCATION (City, town, or county) (State) Balt. Md.
23. FUNERAL DIRECTOR'S SIGNATURE A. Brown Evans		24a. REC'D BY REGISTRAR NOV 19 1956	
ADDRESS 1400 S. Charles St - Balt 30 Md		24b. REGISTRAR'S SIGNATURE Sorothy Newell	

BUREAU V. S.

NOV 19 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 38

11049

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First)	(Middle)	(Month)	(Day)
(Type or Print)		(Year)	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
9. AGE last birthday:		10. IF UNDER 1 YEAR	
		Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
(If Yes, give war or dates of service)			
		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause			
Antecedent causes (s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1955, to 1956, that I last saw the deceased alive on Nov 11, 1956, and that death occurred at 1:00 pm, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 27 1956
BUREAU V. 1

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11050 CERTIFICATE OF DEATH

Reg. Dist. No.

110273

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood St. Tr. School		d. STREET ADDRESS 1809 O'Dell Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lois Middle Carolyn Last Habicht		4. DATE OF DEATH Month November Day 23rd Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/45
9. AGE (In years last birthday) 11 yrs.		10. IF UNDER 1 YEAR: Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton William Habicht		14. MOTHER'S MAIDEN NAME Alice Rebecca Deskins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - static DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac failure DUE TO (c) Cachexia secondary to malnutrition due to severe retardation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) and spastic paraplegia			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/23 , 19 56 , to 11/23/56 , 19 56 , that I last saw the deceased alive on 11/23/ , 19 56 , and that death occurred at 11:30 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter T. Chen		DATE SIGNED 11/23/56	
PHYSICIAN'S NAME (Type) Walter T. Chen, M. D.		ADDRESS (Street, city or town, state) Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Nov 26-56	
22c. NAME OF CEMETERY OR CREMATORY Mountland Mausoleum		22d. LOCATION (City, town, or county) (State) Taylor ave Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Blondard G. Fink		24a. REC'D BY REGISTRAR DATE 11-26-56	
ADDRESS Blow Blow Md.		24b. REGISTRAR'S SIGNATURE Mary Jones	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11028

Reg. Dist. No.

10985

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Relay		c. LENGTH OF STAY IN lb 4 yrs. plus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore / Miss Alice Ekas 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Relay Hill Hospital			d. STREET ADDRESS c/o 4231 Euclid Avenue Baltimore, Md.		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
3. NAME OF DECEASED (Type or print) Sadie First Middle Last			4. DATE OF DEATH Nov. 16, 1956 Month Day Year		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1873	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William Wondrly		
14. MOTHER'S MAIDEN NAME Caroline --			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT 4231 Euclid Avenue Miss Alice Ekas: Longwood 6-8886		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 903.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Urinary tract infection DUE TO (c) Fracture left femur intertrahantiric					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell to floor on smooth surface			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10-19-56 19 p. m. x	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	20f. (City or town) Relay, Baltimore Co., Md.	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Geo. S. M. Kieffer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Nov. 16, 1956	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 19/56	22c. NAME OF CEMETERY OR CREMATORY Leoden Park	22d. LOCATION (City, town, or county) (State) Balto. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witke		ADDRESS 4101 Edmondson Ave		24a. REC'D BY REGISTRAR NOV 20 1956	24b. REGISTRAR'S SIGNATURE Dr. Geo. S. M. Kieffer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NOV 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11051

CERTIFICATE OF DEATH

11029

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 68 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month November Day 1 Year 1956		5. DATE OF BIRTH Month April Day 11 Year 1894	
6. SEX Male		7. COLOR OR RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years to birthday) yrs. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman (Laborer)		10b. KIND OF BUSINESS OR INDUSTRY City Highway Dept.	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Hamburg		14. MOTHER'S MAIDEN NAME Nannie Jacobs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMPHYSEMA 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNDIAGNOSED PULMONARY MASS - Duration unknown. Exploratory Thoracotomy 10-25-56		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 25 , 19 56 , to November 1 , 19 56 , and that death occurred at 4:50 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 11/1/56	
ACTUAL SIGNATURE Joseph M. Miller		M.D. 11/1/56	
PHYSICIAN'S NAME (Type) JOSEPH M. MILLER, M.D., Chief Surgical Service, VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.		ADDRESS 6009 Harford Rd., Balto. 14, Md.	
24. RECD BY REGISTRY NOV 7 1956		24b. REGISTRAR'S SIGNATURE Samson L. Parker	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

BUREAU V. S.

NOV 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11052

CERTIFICATE OF DEATH

11030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY a.a.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 337 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital,				d. STREET ADDRESS Riverside Drive			
3. NAME OF DECEASED (Type or print) GEORGE (NMI) HARTUNG				4. DATE OF DEATH November 2 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/14/81	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker				10b. KIND OF BUSINESS OR INDUSTRY Furniture Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME August Hartung			
14. MOTHER'S MAIDEN NAME Catherine Helfrich				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) SPA			
16. SOCIAL SECURITY NO. 212 03 3872				17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CIRRHOSIS OF THE LIVER. NEPHRITIS, CHRONIC, ARTERIOSCLEROTIC HEART							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DISEASE			
20c. TIME OF INJURY Month, Day, Year VA 19 Hour a. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from December 1 , 19 55 , to November 2 , 19 56 , that I was the deceased's live on XXXXXX and that death occurred at 7:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED XXXXXX							
ACTUAL SIGNATURE C. J. Papastradt M.D.				PHYSICIAN'S NAME (Type) C. J. PAPASTRADT, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-6-56		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) Frederick Ave. Balto, Md.				22e. (State)		22f. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wippert Funeral Home Balto. & Monroe Sts.				ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR 1956	
24b. REGISTRAR'S SIGNATURE Dr. L. L. Farkes				DATE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11038

PLACE OF BIRTH COUNTY STATE		DECEASED NAME SEX AGE	
DATE OF BIRTH MONTH DAY YEAR		PLACE OF DEATH COUNTY STATE	
OCCASION OF DEATH (Check one) <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Unknown		TIME OF DEATH HOUR MINUTE	
STREET ADDRESS CITY STATE ZIP		OCCUPATION (Check one) <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Homemaker <input type="checkbox"/> Other	
MARITAL STATUS (Check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		CAUSE OF DEATH (Check one) <input type="checkbox"/> Heart Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Infection <input type="checkbox"/> Injury <input type="checkbox"/> Poisoning <input type="checkbox"/> Other	
MEDICAL HISTORY (Check one) <input type="checkbox"/> No Known Conditions <input type="checkbox"/> Chronic Conditions <input type="checkbox"/> Acute Conditions <input type="checkbox"/> Unknown		SIGNATURE OF DECEASED (If applicable) DATE	
SIGNATURE OF WITNESS (If applicable) DATE		SIGNATURE OF PHYSICIAN (If applicable) DATE	
SIGNATURE OF CORONER (If applicable) DATE		SIGNATURE OF JUDGE (If applicable) DATE	
SIGNATURE OF CLERK (If applicable) DATE		SIGNATURE OF REGISTRAR (If applicable) DATE	

BUREAU V. 3

NOV 7 1956

RECEIVED

11031 30

Reg. Dist. No.

11053

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.'s Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant, Md.	
c. LENGTH OF STAY IN 1b 2yr1mth11ys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 419 Addison Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Effie Wingate Hastings		4. DATE OF DEATH Month November Day 15 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY — AT HOME —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Stern Wingate		14. MOTHER'S MAIDEN NAME Virginia Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1955 , to Nov. 15, 1956 , that I last saw the deceased alive on Nov. 15, 1956 , and that death occurred at 9:00am , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 11-15-56 PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF Nov 17, 1956	
22c. NAME OF CEMETERY OR CREMATORY Addison Chapel Cem.		22d. LOCATION (City, town, or county) (State) Seat Pleasant Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		24a. REC'D BY REGISTRAR Wash DC	
24b. REGISTRAR'S SIGNATURE W. E. Harry		DATE NOV 19 1956	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11032

10986 CERTIFICATE OF DEATH

Reg. Dist. No.

42

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus, Md.				c. LENGTH OF STAY IN 1b 65 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maiden Choice Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elsie Middle M Last Hastings				4. DATE OF DEATH Month Nov. Day 21 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11-1891	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frederick Vollers				14. MOTHER'S MAIDEN NAME Margaret Schaffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No		17. INFORMANT George Hastings Address Maiden Choice Lane.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiac Vascular Disease DUE TO (c) Stroke						INTERVAL BETWEEN ONSET AND DEATH 9 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from March , 19 58 , to Mar 21 , 19 56 , that I last saw the deceased alive on Mar 20 , 19 56 , and that death occurred at 29 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Albert Scagnetti M.D.				ADDRESS (Street, city or town, state) 1729 W Lombard St			
PHYSICIAN'S NAME (Type) ALBERT SCAGNETTI				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 24-56.		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Frederick Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edmund Perry				ADDRESS 5646 Carville Ave.			
24a. REC'D BY REGISTRAR DATE 27 1956				24b. REGISTRAR'S SIGNATURE Dr. Geo M. Kueffer			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. PLACE OF DEATH		11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE		19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER		28. SIGNATURE OF INTERVIEWER	
29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER		31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER	
33. SIGNATURE OF INTERVIEWER		34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWER	
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 OCT 2 1956
 BUREAU V. 8

10971

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G207 11-26-56 et

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLGATE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7603 RIDDLE AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Archie Middle HAYNES Last HAYNES		4. DATE OF DEATH Month NOV Day 6 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 11, 1879
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer Ret		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD
13. FATHER'S NAME Don't Know		14. MOTHER'S MAIDEN NAME Don't Know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Marie Connor 501 Lawrence Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 1th	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE JACK C COLLINS		DATE SIGNED 11-6-56	
EXAMINER'S NAME (Type) JACK C COLLINS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov 9/56 Oak Lawn	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Balto Co
23. FUNERAL DIRECTOR'S SIGNATURE William L. Ford Home 2112 Dundalk Ave		24a. REC'D BY REGISTRAR NOV 14 1956 DATE	
ADDRESS		24b. REGISTRAR'S SIGNATURE Mr. Kelly	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____ SEX _____ AGE _____ PLACE OF BIRTH _____ OCCUPATION _____ MARITAL STATUS _____ DATE OF DEATH _____ TIME OF DEATH _____ PLACE OF DEATH _____ CAUSE OF DEATH _____ MANNER OF DEATH _____ SIGNATURE OF EXAMINER _____ OFFICE OF THE EXAMINER _____ COUNTY _____ STATE _____ DATE OF EXAMINATION _____ TIME OF EXAMINATION _____ PLACE OF EXAMINATION _____ SIGNATURE OF WITNESS _____ OFFICE OF THE WITNESS _____ COUNTY _____ STATE _____ DATE OF EXAMINATION _____ TIME OF EXAMINATION _____ PLACE OF EXAMINATION _____	
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BUREAU V. S.

NOV 14 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 45

11054

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>440 Whitethorn Way</u>				d. STREET ADDRESS <u>440 Whitethorn Way</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Lawrence Hedderman</u>				4. DATE OF DEATH Month Day Year <u>November 13, 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/1898</u>		9. AGE (In years last birthday) yrs. <u>58</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Procurement Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hedderman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-12-6367</u>		17. INFORMANT Address <u>Pearl May Hedderman Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of bladder</u> 181x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stomach ulcer of jejunum</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/19/56</u> 19 <u>56</u> , to <u>11/13/56</u> 19 <u>56</u> , that I last saw the deceased alive on <u>11/12/56</u> 19 <u>56</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Nicelli</u> M.D. <u>423 Eastern Ave</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>11/13/56</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH NICELLI</u>				<u>Essay 21 Ind</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Bruzdinski</u> ADDRESS <u>1407 Eastern Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>11/13/56</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Huley</u>	

10

54

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JUDGE		14. SIGNATURE OF CLERK		15. SIGNATURE OF OFFICIAL	
16. SIGNATURE OF OFFICIAL		17. SIGNATURE OF OFFICIAL		18. SIGNATURE OF OFFICIAL	
19. SIGNATURE OF OFFICIAL		20. SIGNATURE OF OFFICIAL		21. SIGNATURE OF OFFICIAL	
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100. SIGNATURE OF OFFICIAL		101. SIGNATURE OF OFFICIAL		102. SIGNATURE OF OFFICIAL	

BUREAU V. J.

NOV 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11055 CERTIFICATE OF DEATH

11035 30

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 609 Aldershot Road		d. STREET ADDRESS 609 Aldershot Road	
3. NAME OF DECEASED (Type or print) CHARLES First HELLEN Middle HELEN Last		4. DATE OF DEATH NOV-27 Month Nov Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 19, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Ind. Trust	
11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hellen		14. MOTHER'S MAIDEN NAME Lillian Bignon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 617-14-5523	
17. INFORMANT Carrie M. Hellen Address 609 Aldershot Rd #9			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic C.V.D. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953, 1956 to 11/27, 1956 , that I last saw the deceased alive on 11/2, 1956 , and that death occurred at E.A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. C. Pound		ADDRESS (Street, city or town, state) 3225 Frederick Ave Baltimore Md	
PHYSICIAN'S NAME (Type) J.C. Pound		DATE SIGNED 11/27/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 30, 1956	
22c. NAME OF CEMETERY OR CREMATORY Westminster		22d. LOCATION (City, town, or county) (State) Westminster Md Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Gimpel ADDRESS 5311 Edmondson Ave		24a. REC'D BY REGISTRAR NOV 28 1956 DATE	
24b. REGISTRAR'S SIGNATURE V. E. Perry			

NOV 28 1956

RECEIVED

11055 CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Balti</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <i>Baltimore-rural</i>		TOWN <i>Baltimore-rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Box 190-Route 16-Bird River Rd.</i>		STREET ADDRESS (If rural give location) <i>Box 190-Route 16-Bird River Rd.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>John F. Heine</i>		DEATH: <i>Nov. 22 1956</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i>June 6, 1874</i>
			9. AGE last birthday <i>82</i> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <i>At Home</i>	11. BIRTHPLACE (State or foreign country): <i>Balta. Md.</i>
13. FATHER'S NAME: <i>Mr. Heine</i>		14. MOTHER'S MAIDEN NAME: <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-01-4153</i>	17. INFORMANT & ADDRESS: <i>Daniel J. Heine Sr. - 605 N. Curley St.</i>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>Broncho-pneumonia</i>			<i>7 days</i>
ANTECEDENT CAUSE (S) (B) <i>Multiple cerebral</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <i>Thromboses</i>			<i>18 months</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>July 1953</i> to <i>Nov 22, 1956</i> , that I last saw the deceased alive on <i>Jan 22, 1956</i> , and that death occurred at <i>1940 St.</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Joseph Mouch</i>		ADDRESS <i>108 S. Taylor</i> DATE SIGNED <i>11/23/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>11-26-56</i>	NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cem.</i>
LOCATION (City, town, or county) (State) <i>Balta. Md.</i>		24. FUNERAL DIRECTOR ADDRESS <i>John C. Miller Inc. - 243 S. E. Oliver St.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>November 24, 1956</i>		REGISTRAR'S SIGNATURE <i>R.W.</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7/2/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11057 CERTIFICATE OF DEATH

11037 27

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1652 Shadyside Rd.			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle P. Last HESSINGER				4. DATE OF DEATH Month Nov. Day 29 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1865	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Quartermaster's Dept. (Civilian) U.S. Govt				10b. KIND OF BUSINESS OR INDUSTRY Penna.		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Theodore Hessinger				14. MOTHER'S MAIDEN NAME Caroline Engelkirk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Edwin K. Clickner - 3426 - 16th St. N. W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mixed organism DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchitis, generalized arterio-sclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/8/54 , 19____, to present , 19____, that I last saw the deceased alive on 11/29 , 19____, and that death occurred at 12:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest C Brown				ADDRESS (Street, city or town, state) 1101 N. Calvert St, Balt. Md		DATE SIGNED 11/30/56	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/56		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edm. J. Tisler & Sons - Balt 17, Md.				24a. REC'D BY REGISTRAR DATE 12/4/56		24b. REGISTRAR'S SIGNATURE Ernest MacRae	

RECEIVED
DEC 5 1956
BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11058 CERTIFICATE OF DEATH

11038 38
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1835 Edgewood Road</u>				d. STREET ADDRESS <u>1835 Edgewood Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Miss Regina E. Hieber</u>				4. DATE OF DEATH <u>November 18th 1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 18, 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Worker, Comptometer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Hieber</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Auffarth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Margaret Hieber, 1835 Edgewood Road.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>Metastatic breast carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>170x</u> (c) <u>15yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 12, 1954</u> to <u>Nov 18, 1956</u> , that I last saw the deceased alive on <u>Nov 15, 1956</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert E. Gray</u> M.D.				ADDRESS (Street, city or town, state) <u>1200 Woodbourne Av. Balto 12 Md.</u>			
DATE SIGNED <u>Nov. 19, 1956</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/1/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road.</u> ADDRESS				24a. RECEIVED BY REGISTRAR <u>Mabel Gray</u>		24b. REGISTRAR'S SIGNATURE	

1999

BUREAU V. S.

NOV 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

11039

2411 N. Charles Street, Baltimore

Dr. Gordon Grau:

CERTIFICATE OF DEATH

Reg. Dist. No.....

11059

1. PLACE OF DEATH CITY/TOWN: <u>Baltimore Co.</u> STATE: <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE: <u>Maryland</u> COUNTY: <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO (4) Co.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO (4) Co.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS: <u>1777 Amuskai Rd.</u>		STREET ADDRESS (If rural, give location): <u>1777 Amuskai Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CATHERINE M. HIGGINS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11/17/56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1907</u>
9. AGE last birthday <u>49</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Stores</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Wilbur Rowe</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. M.H.Higgins-1777 Amuskai Rd.</u>	
17. INFORMANT AND ADDRESS <u>Mr. M.H.Higgins-1777 Amuskai Rd.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

171X Immediate cause (a) Carcinoma of cervix

4 yrs

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>11/4/52</u>		19b. MAJOR FINDINGS OF OPERATION <u>Guanoma cell carcinoma of cervix</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>INJURY</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 6/1/52, 1952, to 11/17, 1956, that I last saw the deceased alive on 11/17, 1956, and that death occurred at m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11/21/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto.</u>	
DATE REC'D BY LOCAL REG. <u>11/22/56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>WIEDEFELD & SON</u>		ADDRESS <u>GREENMOUNT AVE & 22ND</u>	

MARGIN RESERVED FOR BUNDLING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11/20/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG207 12-5-56 et

CERTIFICATE OF DEATH

11040

Reg. Dist. No.

37

11069

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		d. STREET ADDRESS <u>104 W. University Parkway</u>	
3. NAME OF DECEASED (Type or print) First <u>Adele</u> Middle <u>Thomas</u> Last <u>Hilgartner</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Not obtainable</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Edwin F. Hoffmaster</u>		Address <u>3832 Arbutus Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA—UTERUS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 JUNE, 1947</u> to <u>27 NOV, 1956</u> , that I last saw the deceased alive on <u>26 Nov, 1956</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. De Hoff</u>		DATE SIGNED <u>2020 N Charles St</u>	
PHYSICIAN'S NAME (Type) <u>John B. De Hoff</u>		ADDRESS (Street, city or town, state) <u>Baltimore 18, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Mears & Son</u>		ADDRESS <u>8-5 N. Calvert Street</u>	
24a. REC'D BY REGISTRAR <u>NOV 30 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Arue Mac Raey</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10

1. NAME OF DECEASED JAMES J. JAMES		2. SEX M		3. AGE 45		4. DATE OF DEATH 11-30-1956	
5. PLACE OF DEATH HOME		6. STREET ADDRESS 123 MAIN ST.		7. CITY BOSTON		8. STATE MASS.	
9. OCCUPATION Carpenter		10. MARITAL STATUS Married		11. EDUCATION High School		12. RELIGION Roman Catholic	
13. CAUSE OF DEATH Heart Disease		14. MANNER OF DEATH Natural		15. PLACE OF BIRTH New York		16. DATE OF BIRTH 11-15-1911	
17. SIGNATURE OF DECEASED James J. James		18. SIGNATURE OF WITNESSES John J. James		19. SIGNATURE OF PHYSICIAN Dr. J. J. James		20. SIGNATURE OF REGISTRAR J. J. James	
21. SIGNATURE OF DECEASED James J. James		22. SIGNATURE OF WITNESSES John J. James		23. SIGNATURE OF PHYSICIAN Dr. J. J. James		24. SIGNATURE OF REGISTRAR J. J. James	
25. SIGNATURE OF DECEASED James J. James		26. SIGNATURE OF WITNESSES John J. James		27. SIGNATURE OF PHYSICIAN Dr. J. J. James		28. SIGNATURE OF REGISTRAR J. J. James	
29. SIGNATURE OF DECEASED James J. James		30. SIGNATURE OF WITNESSES John J. James		31. SIGNATURE OF PHYSICIAN Dr. J. J. James		32. SIGNATURE OF REGISTRAR J. J. James	
33. SIGNATURE OF DECEASED James J. James		34. SIGNATURE OF WITNESSES John J. James		35. SIGNATURE OF PHYSICIAN Dr. J. J. James		36. SIGNATURE OF REGISTRAR J. J. James	
37. SIGNATURE OF DECEASED James J. James		38. SIGNATURE OF WITNESSES John J. James		39. SIGNATURE OF PHYSICIAN Dr. J. J. James		40. SIGNATURE OF REGISTRAR J. J. James	
41. SIGNATURE OF DECEASED James J. James		42. SIGNATURE OF WITNESSES John J. James		43. SIGNATURE OF PHYSICIAN Dr. J. J. James		44. SIGNATURE OF REGISTRAR J. J. James	
45. SIGNATURE OF DECEASED James J. James		46. SIGNATURE OF WITNESSES John J. James		47. SIGNATURE OF PHYSICIAN Dr. J. J. James		48. SIGNATURE OF REGISTRAR J. J. James	
49. SIGNATURE OF DECEASED James J. James		50. SIGNATURE OF WITNESSES John J. James		51. SIGNATURE OF PHYSICIAN Dr. J. J. James		52. SIGNATURE OF REGISTRAR J. J. James	
53. SIGNATURE OF DECEASED James J. James		54. SIGNATURE OF WITNESSES John J. James		55. SIGNATURE OF PHYSICIAN Dr. J. J. James		56. SIGNATURE OF REGISTRAR J. J. James	
57. SIGNATURE OF DECEASED James J. James		58. SIGNATURE OF WITNESSES John J. James		59. SIGNATURE OF PHYSICIAN Dr. J. J. James		60. SIGNATURE OF REGISTRAR J. J. James	
61. SIGNATURE OF DECEASED James J. James		62. SIGNATURE OF WITNESSES John J. James		63. SIGNATURE OF PHYSICIAN Dr. J. J. James		64. SIGNATURE OF REGISTRAR J. J. James	
65. SIGNATURE OF DECEASED James J. James		66. SIGNATURE OF WITNESSES John J. James		67. SIGNATURE OF PHYSICIAN Dr. J. J. James		68. SIGNATURE OF REGISTRAR J. J. James	
69. SIGNATURE OF DECEASED James J. James		70. SIGNATURE OF WITNESSES John J. James		71. SIGNATURE OF PHYSICIAN Dr. J. J. James		72. SIGNATURE OF REGISTRAR J. J. James	
73. SIGNATURE OF DECEASED James J. James		74. SIGNATURE OF WITNESSES John J. James		75. SIGNATURE OF PHYSICIAN Dr. J. J. James		76. SIGNATURE OF REGISTRAR J. J. James	
77. SIGNATURE OF DECEASED James J. James		78. SIGNATURE OF WITNESSES John J. James		79. SIGNATURE OF PHYSICIAN Dr. J. J. James		80. SIGNATURE OF REGISTRAR J. J. James	
81. SIGNATURE OF DECEASED James J. James		82. SIGNATURE OF WITNESSES John J. James		83. SIGNATURE OF PHYSICIAN Dr. J. J. James		84. SIGNATURE OF REGISTRAR J. J. James	
85. SIGNATURE OF DECEASED James J. James		86. SIGNATURE OF WITNESSES John J. James		87. SIGNATURE OF PHYSICIAN Dr. J. J. James		88. SIGNATURE OF REGISTRAR J. J. James	
89. SIGNATURE OF DECEASED James J. James		90. SIGNATURE OF WITNESSES John J. James		91. SIGNATURE OF PHYSICIAN Dr. J. J. James		92. SIGNATURE OF REGISTRAR J. J. James	
93. SIGNATURE OF DECEASED James J. James		94. SIGNATURE OF WITNESSES John J. James		95. SIGNATURE OF PHYSICIAN Dr. J. J. James		96. SIGNATURE OF REGISTRAR J. J. James	
97. SIGNATURE OF DECEASED James J. James		98. SIGNATURE OF WITNESSES John J. James		99. SIGNATURE OF PHYSICIAN Dr. J. J. James		100. SIGNATURE OF REGISTRAR J. J. James	

BUREAU V. S.

NOV 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11041

11061

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1404 Mountmor Court			
3. NAME OF DECEASED (Type or print) First CHRISTOPHER Middle (NMI) Last HILL				4. DATE OF DEATH Month November Day 10 Year 19 56			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/38	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? N U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME MARY ELLEN (MN: UNKNOWN)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-01-2766		17. INFORMANT Address Clin.Rec.Vets.Admin.Hospital,Ft.Howard,Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC BRAIN SYNDROME 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 1. Senile arteriosclerotic nephrosclerosis 2. Stricture of urethra 3. Arteriosclerotic cardiovascular disease 4. Chronic cystitis 5. Leukoplakia of bladder							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 21, 19 56 , to November 10, 19 56 , and that death occurred at 12:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Veterans Administration Hospital 11/11/56							
ACTUAL SIGNATURE Caridad E. Gonzalez M.D.				PHYSICIAN'S NAME (Type) CARIDAD GONZALEZ, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law, Mortuary, 802-04 Madison Ave., Balto.				24a. REC'D BY REGISTRAR NOV 14 1956			
				24b. REGISTRAR'S SIGNATURE Samuel L. Lacey			

11062 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1204 Culvert Road</i>		d. STREET ADDRESS <i>1204 Culvert Road</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Charles J. Holthaus</i>		4. DATE OF DEATH Month <i>November</i> Day <i>5</i> Year <i>1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 22, 1896</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Talluman, (Ship)</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>59</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Frederick Holthaus</i>		14. MOTHER'S MAIDEN NAME <i>Bridget Mc Call</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-09-5808</i>	
17. INFORMANT <i>Mrs. Helena Holthaus</i>		Address <i>1204 Culvert Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Decompensative Cardiovascular Disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerosis</i> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While _____ Not while _____ of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <i>Sept 1</i> , 19 <i>56</i> to <i>Nov. 5</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Nov. 5</i> , 19 <i>56</i> , and that death occurred at <i>7:15 P.</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lawrence C. Post</i>		ADDRESS (Street, City or town, State) <i>6105 York Rd. Baltimore Md</i>	
PHYSICIAN'S NAME (Type) <i>LAWRENCE C. POST</i>		DATE SIGNED <i>11/6/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/8/1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REGD BY REGISTRAR DATE <i>Nov. 7, 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11043

11063

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
c. LENGTH OF STAY IN 1b <u>33 yrs</u>				d. STREET ADDRESS <u>113 Rosewood Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pine Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eleanor</u> First <u>Hoofnagle</u> Middle <u>Hoofnagle</u> Last			4. DATE OF DEATH <u>11/14/56</u> Month <u>11</u> Day <u>14</u> Year <u>19</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/3/1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>William Hoofnagle</u>				14. MOTHER'S MAIDEN NAME <u>Cwings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>4427</u>		17. INFORMANT <u>Dr. Robert E. Hoofnagle</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>4427</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension Cardiovascular-Renal Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 da</u> <u>15 yr (?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-14</u> 19 <u>49</u> , to <u>11-14</u> 19 <u>56</u> , that I last saw the deceased alive on <u>11-13</u> 19 <u>56</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D. <u>6209 Frederick Ave.</u>						ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u> <u>Bald. 28, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Hart & Son</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR DATE <u>11/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>T. E. Harry</u>	

10972 CERTIFICATE OF DEATH

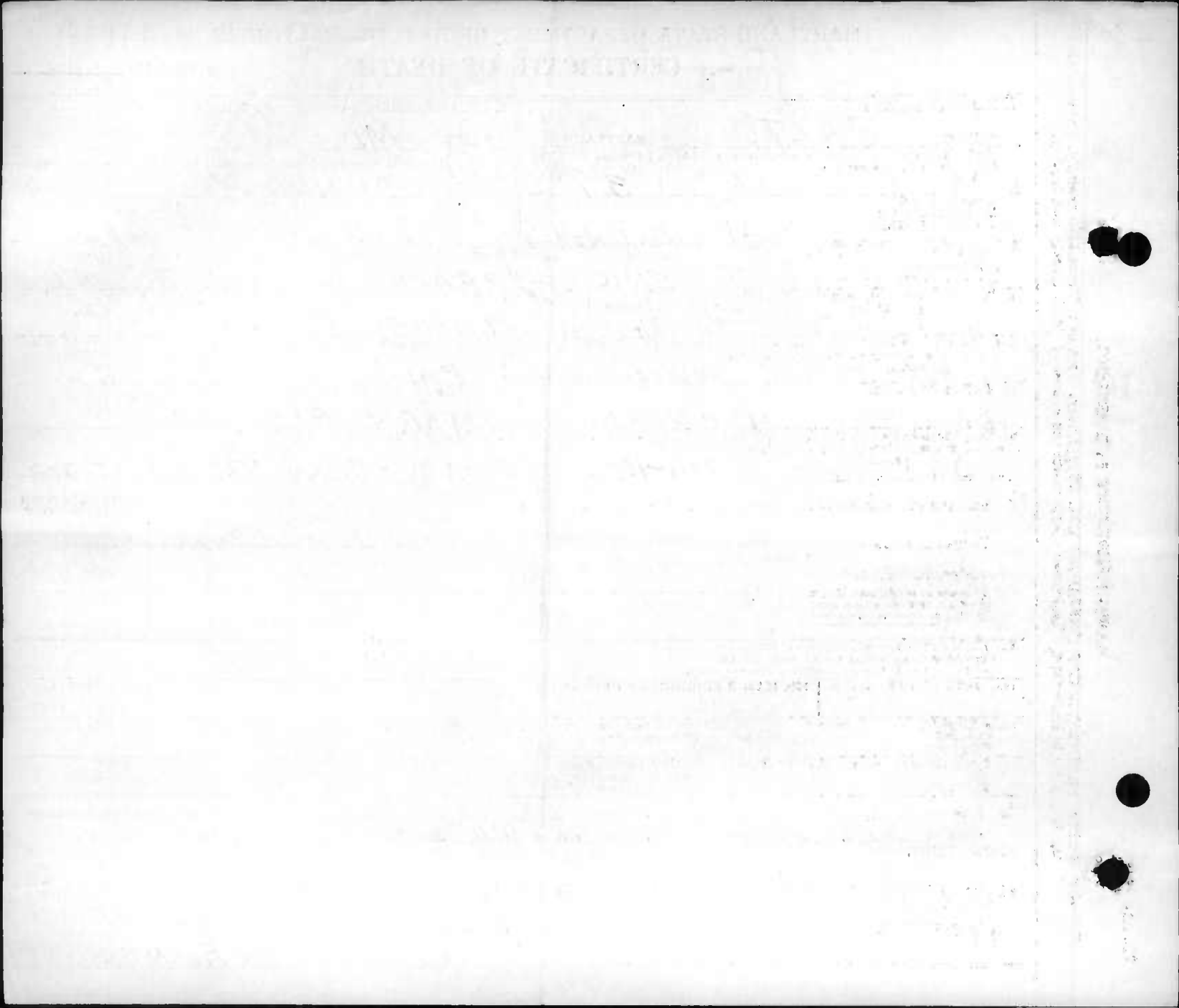
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>DUNDALK</u>		LENGTH OF STAY (in this place) <u>3 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK</u>		<u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1922 AUGUST AVE</u>				STREET ADDRESS (If rural, give location) <u>1922 AUGUST AVE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>BENNETT ERIC HUBBARD</u>				<u>NOV. 3 1956</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>MARRIED AUG. 17, 1903</u>	9. AGE last birthday: <u>53</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>PIPE FITTER</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>AMERICAN SMELTING</u>	11. BIRTHPLACE (State or foreign country): <u>BALTO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>SAMUEL HUBBARD</u>				14. MOTHER'S MAIDEN NAME: <u>MARY PINDELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY No.: <u>212-10-2102</u>		17. INFORMANT & ADDRESS: <u>CLARA M. HUBBARD 1925 AUGUST AVE</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Generalized metastasis following malignancy of left kidney</u>							
Antecedent cause(s) (b) <u>of left kidney</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>Nov. 31, 1955</u>				19b. MAJOR FINDINGS OF OPERATION: <u>malignancy 7 kidney</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		CITY OR TOWN		(COUNTY) (STATE)	
<u>HOMICIDE</u>		<u>INJURY</u>		<u>1145 AM</u>		<u>NOV 3 1956</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
<u>1145 AM</u>		<u>at work</u>		<u>fall</u>			
22. I hereby certify that I attended the deceased from <u>Nov 3, 1956</u> to <u>Nov 3, 1956</u> , that I last saw the deceased alive on <u>Nov 3, 1956</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Eric Bennett</u>				DATE SIGNED <u>11/3/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>NOV. 6 56</u>		NAME OF CEMETERY OR CREMATORY: <u>BALTO. CEM.</u>		LOCATION (City, town, or county) (State): <u>E. NORTH AVE BALTO. MD</u>	
DATE RECD BY LOCAL REG. <u>11/6/56</u>		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR: <u>W. J. Bros 1800 E. LOMBARD ST</u>			

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11064

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mth 1 dy.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3719 W. Garrison 4007/1 RAGWOOD Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mollie Middle Rebecca Last Huber		4. DATE OF DEATH Month Nov. Day 25 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dressmaker		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Huber		14. MOTHER'S MAIDEN NAME Elizabeth DeBus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-10-8632	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chlorpromazine jaundice		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 25, 19 56 , to Nov. 25, 19 56 , that I last saw the deceased alive on Nov. 25, 19 56 , and that death occurred at 4:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11-26-56			
ACTUAL SIGNATURE Stella Wachler M.D.			
PHYSICIAN'S NAME (Type) Stella Wachler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/56	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto 17, Md.		24a. REC'D BY REGISTRAR Nov. 28, 1956	
24b. REGISTRAR'S SIGNATURE J. E. Harry			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 29 1956

RECEIVED

11065 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Providence		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Providence	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Providence Road		d. STREET ADDRESS Providence Road	
3. NAME OF DECEASED (Type or print) ALEXANDER ISAAC WAYNE JACKSON		4. DATE OF DEATH Month November Day 16 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1894
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Baker—retired		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A. I. Wayne Jackson		14. MOTHER'S MAIDEN NAME Catherine Kemp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO YES		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage with right hemiplegia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 1952, to Nov 16 , 1956, that I last saw the deceased alive on Nov 16 , 1956, and that death occurred at 9:35 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Rollin C. Hudson		ADDRESS (Street, city or town, state) 606 Baltimore Ave Towson 4 Md	
PHYSICIAN'S NAME (Type) Rollin C. Hudson		DATE SIGNED 11/18/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29, 1956	
22c. NAME OF CEMETERY OR CREMATORY Mt. Merie Cemetery		22d. LOCATION (City, town, or county) (State) Towson, Maryland	
23a. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS Towson, Maryland	
24a. REC'D BY REGISTRAR 11/19/56		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

BUREAU V. S.

21 1956

RECEIVED

11066

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hosp.</u>		d. STREET ADDRESS <u>403 S. Charles St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>James</u> Last <u>James</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>62</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Praybiter & Smith, M.D. Sp. Insp.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiovascular disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic alcoholism</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 27, 1956</u> to <u>Nov. 17, 1956</u> , that I last saw the deceased alive on <u>Nov. 17, 1956</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Ward</u>		ADDRESS (Street, city or town, state) <u>Spring Grove Hosp - 11/18/56</u>	
PHYSICIAN'S NAME (Type) <u>DR. CHARLES WARD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/21/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. DENNY, INC</u>		ADDRESS <u>715 LIGHT ST</u>	24a. REC'D BY REGISTRAR <u>DATE 11-21-56</u>
		24b. REGISTRAR'S SIGNATURE <u>Victor C. Harry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 9, Film G207, 11/23/56 bh

CERTIFICATE OF DEATH

Reg. Dist. No.

11048

11067

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balt.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Douglas Memorial Church Home		d. STREET ADDRESS Frederick Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ROSE G. JAMES		4. DATE OF DEATH Month Day Year Nov. 14, 1956	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widow Unknown	8. DATE OF BIRTH Nov. 14, 1900
9. AGE (In years last birthday) 57 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 57 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Corrine Bolling-Matron Douglas Memorial Church Home
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Mitral Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonitis (Virus Infection) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 22 days 10 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 10-23-56 , 19____, to 11-15-56 , 19____, that I last saw the deceased alive on 11-15-56 , 19____, and that death occurred at 11:30 AM , from the causes and on the date stated above. C. F. Maloney, M.D. ADDRESS (Street, city or town, state) 57 Winters Lane, Balto. DATE SIGNED 11/16/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF Nov. 17, '56		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
22d. LOCATION (City, town, or county) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE 1601 David Hill Ave.		24a. REC'D BY REGISTRAR NOV 19 1956	
24b. REGISTRAR'S SIGNATURE V. E. Harris			

CERTIFICATE OF DEATH

Name of Deceased Catherine		Sex Female	
Place of Birth Cathartsville		Date of Birth Nov. 11, 1900	
Usual Residence Porter Memorial Church Lane		Date of Death Nov. 11, 1956	
Cause of Death Lymphadenoma		Place of Death Home	
Occupation None		Manner of Death Natural	
Signature of Physician J. Edgar		Signature of Registrar J. Edgar	
Signature of Coroner J. Edgar		Signature of Medical Examiner J. Edgar	
Signature of Burial Officer J. Edgar		Signature of Undertaker J. Edgar	
Signature of Funeral Home J. Edgar		Signature of Cemetery J. Edgar	
Signature of Health Officer J. Edgar		Signature of County Health Officer J. Edgar	
Signature of State Health Officer J. Edgar		Signature of Federal Health Officer J. Edgar	

BUREAU V. 2

NOV 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11049

11068

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 294 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 5503 Belair Road			
3. NAME OF DECEASED (Type or print) First FRANK Middle J. Last JASPER				4. DATE OF DEATH Month November Day 27 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 12, 1889	
9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman				10b. KIND OF BUSINESS OR INDUSTRY Distillery		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Frank Jasper				14. MOTHER'S MAIDEN NAME Wilhelmina Goeller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW I				16. SOCIAL SECURITY NO. 215-22-6692		17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LEFT LUNG WITH METASTASIS TO THE CHEST WALL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 163X (b) UNKNOWN (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Diabetes mellitus 2. Generalized arteriosclerosis. 3. Above knee amputation, left. 4. Gangrene of the right big toe						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 7, 1956 , to November 27, 1956 , and that death occurred at 11:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. J. Papastrat, M.D. M.D. VAH, FORT HOWARD, MARYLAND 11/28/56							
ACTUAL SIGNATURE C. J. Papastrat, M.D. M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 11/28/56							
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-56		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				ADDRESS 6009 Harford Rd., Balto., Md.		24a. REC'D BY REGISTRAR DEC 3 1956	
24b. REGISTRAR'S SIGNATURE Newson L. Loring							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		38		January 12, 1920	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main Street, Baltimore, Md.		Carpenter		Myocardial Infarction		Natural	
DATE OF DEATH		PLACE OF DEATH		HOSPITAL		PHYSICIAN	
January 15, 1958		Home		St. Joseph's Hospital		Dr. J. H. Smith	
TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE	
10:30 AM		98.6 F		72		120/80	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION	
[Signature]		[Signature]		January 16, 1958		Baltimore, Md.	

BUREAU V. S.

DEC 3 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

38

11069

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lutheran Deaconess Home				d. STREET ADDRESS 1100 Boyce Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Sophia First Middle Last SOPHIA JEPSON				4. DATE OF DEATH Month November Day 30 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov: 12, 1861	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deaconess		10b. KIND OF BUSINESS OR INDUSTRY Lutheran Home		11. BIRTHPLACE (State or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Jens Sorrensen				14. MOTHER'S MAIDEN NAME Anna Nielsen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records Lutheran Home 1100 Boyce Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility.						INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-29, 1956 , to 11-30, 1956 , that I last saw the deceased alive on 11-29, 1956 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. L. Ewald Jr.				ADDRESS (Street, city or town, state) 36 YORK COURT			
PHYSICIAN'S NAME (Type) A. L. EWALD JR.				DATE SIGNED 12-1-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec: 3, 1956		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery Woodlawn Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. B. Whiffert				ADDRESS 1300 Eutaw Place		24a. REC'D BY REGISTRAR DATE 12/6/56	
				24b. REGISTRAR'S SIGNATURE Mabel Gray			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11051

11070

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH a. COUNTY Sweet Air Balto., Co., MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b 10 yrs.				Sweet Air, Balto. Co., Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Sweet Air			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Myrtle Augusta Jessop				4. DATE OF DEATH Month Day Year Nov. 20 19 56			
5. SEX Female		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1898	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James R. Smith		14. MOTHER'S MAIDEN NAME Lotta Cunningham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Stewart M. Jessop		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Congestive Heart Failure DUE TO (b) Hypertensive Cardiovascular Dis 10 yrs. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 11, 19 57, to Nov. 20, 19 56, that I last saw the deceased alive on Nov. 20, 19 56, and that death occurred at 3 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Clifford F. Hudson, M.D.				ADDRESS (Street, city or town, state) Fork, Md.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-1956		22c. NAME OF CEMETERY OR CREMATORY Chesnut Grove		22d. LOCATION (City, town, or county) (State) Sweet Air, Balto., Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Jenkins & Sons 4905 York Rd				ADDRESS		24a. REC'D BY REGISTRAR DATE 11-23-56	
24b. REGISTRAR'S SIGNATURE Elizabeth Granch							

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>James M. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Nov 23 1956</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md</i>	
10. OCCUPATION <i>Engineer</i>		11. EDUCATION <i>High School</i>		12. RELIGION <i>Methodist</i>	
13. MARITAL STATUS <i>Married</i>		14. NAME OF SPOUSE <i>John M. Smith</i>		15. NAME OF PHYSICIAN <i>Dr. J. M. Smith</i>	
16. NAME OF FUNERAL HOME <i>Smith & Sons</i>		17. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		18. SIGNATURE OF DECEASED <i>James M. Smith</i>	
19. SIGNATURE OF WITNESS <i>John M. Smith</i>		20. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		21. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>	
22. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>		23. SIGNATURE OF DECEASED <i>James M. Smith</i>		24. SIGNATURE OF WITNESS <i>John M. Smith</i>	
25. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		26. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>		27. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>	
28. SIGNATURE OF DECEASED <i>James M. Smith</i>		29. SIGNATURE OF WITNESS <i>John M. Smith</i>		30. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>	
31. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>		32. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>		33. SIGNATURE OF DECEASED <i>James M. Smith</i>	
34. SIGNATURE OF WITNESS <i>John M. Smith</i>		35. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		36. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>	
37. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>		38. SIGNATURE OF DECEASED <i>James M. Smith</i>		39. SIGNATURE OF WITNESS <i>John M. Smith</i>	
40. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		41. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>		42. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>	
43. SIGNATURE OF DECEASED <i>James M. Smith</i>		44. SIGNATURE OF WITNESS <i>John M. Smith</i>		45. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>	
46. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>		47. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>		48. SIGNATURE OF DECEASED <i>James M. Smith</i>	
49. SIGNATURE OF WITNESS <i>John M. Smith</i>		50. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		51. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>	
52. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>		53. SIGNATURE OF DECEASED <i>James M. Smith</i>		54. SIGNATURE OF WITNESS <i>John M. Smith</i>	
55. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		56. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>		57. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>	
58. SIGNATURE OF DECEASED <i>James M. Smith</i>		59. SIGNATURE OF WITNESS <i>John M. Smith</i>		60. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>	
61. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>		62. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>		63. SIGNATURE OF DECEASED <i>James M. Smith</i>	
64. SIGNATURE OF WITNESS <i>John M. Smith</i>		65. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		66. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>	
67. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>		68. SIGNATURE OF DECEASED <i>James M. Smith</i>		69. SIGNATURE OF WITNESS <i>John M. Smith</i>	
70. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		71. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>		72. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>	
73. SIGNATURE OF DECEASED <i>James M. Smith</i>		74. SIGNATURE OF WITNESS <i>John M. Smith</i>		75. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>	
76. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>		77. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>		78. SIGNATURE OF DECEASED <i>James M. Smith</i>	
79. SIGNATURE OF WITNESS <i>John M. Smith</i>		80. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		81. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>	
82. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>		83. SIGNATURE OF DECEASED <i>James M. Smith</i>		84. SIGNATURE OF WITNESS <i>John M. Smith</i>	
85. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		86. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>		87. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>	
88. SIGNATURE OF DECEASED <i>James M. Smith</i>		89. SIGNATURE OF WITNESS <i>John M. Smith</i>		90. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>	
91. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>		92. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>		93. SIGNATURE OF DECEASED <i>James M. Smith</i>	
94. SIGNATURE OF WITNESS <i>John M. Smith</i>		95. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		96. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>	
97. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>		98. SIGNATURE OF DECEASED <i>James M. Smith</i>		99. SIGNATURE OF WITNESS <i>John M. Smith</i>	
100. SIGNATURE OF PHYSICIAN <i>Dr. J. M. Smith</i>		101. SIGNATURE OF FUNERAL HOME <i>Smith & Sons</i>		102. SIGNATURE OF BURIAL PLACE <i>Greenwood Cemetery</i>	

RECEIVED

NOV 23 1956

BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 11052

CERTIFICATE OF DEATH

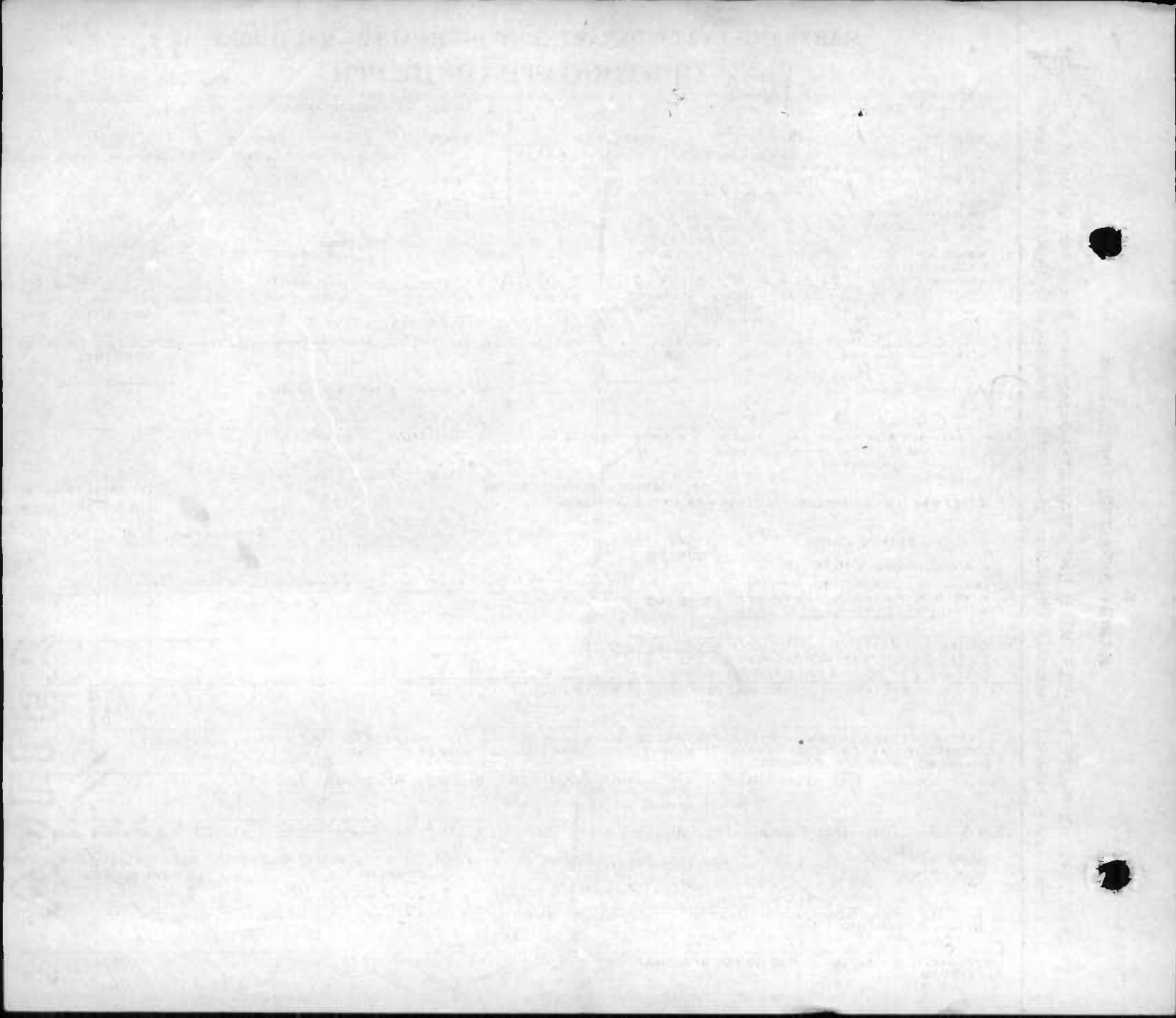
Reg. Dist. No.

11071

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	BALTIMORE MARYLAND	STATE	Md. COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL OR and give nearest town)	RASPEBURG	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	RASPEBURG
HOSPITAL OR INSTITUTION OR STREET ADDRESS	292 Ridge Rd BALTO. 6	STREET ADDRESS (If rural give location)	292 Ridge Rd BALTO. 6
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
LAURA V. JOHNSON		11 - 11 1956	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
F.	C.	WIDOWED	5-16-1876
9. AGE last birthday		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
80 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
Housewife		Md.	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Md.			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
HENRY PRESCOE		MARY WILLIAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT & ADDRESS:			
Wesley P. Johnson			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) DUE TO			422.1 Congestive Heart Failure 2 weeks
ANTECEDENT CAUSE (B) DUE TO			Arteriosclerotic Cardiovascular Disease
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			Simone
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
Fertility			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
0			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from October, 1956, to November, 1956, that I last saw the deceased alive on Oct. 30, 1956, and that death occurred at 7 AM, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
A. Andrew Alece		11/12/56	
M.D. 13 E. Egan St. #2			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
BURIAL		11-14-56	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
PUTTY HILL		BALTO. COUNTY, MD	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
11/13/56			
24. FUNERAL DIRECTOR		ADDRESS	
Joseph B. Locko		1304 N. Central Ave	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11072 CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 132 Lincoln Ave.				d. STREET ADDRESS 132 Lincoln Ave.			
3. NAME OF DECEASED (Type or print) WILLIAM HENRY JONES Jr.				4. DATE OF DEATH Month Nov. Day 2 Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 81 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Home-caretaker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Jones, Sr.				14. MOTHER'S MAIDEN NAME Elizabeth Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Emma Jones Address 132 Lincoln Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH minutes hour week							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/13/26 to 7/20/56 , that I last saw the deceased alive on 7/20/56 , and that death occurred at 6:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lutherville DATE SIGNED 11/4/56							
ACTUAL SIGNATURE Bennett A. Stoen M.D.				PHYSICIAN'S NAME (Type) Bennett A. Stoen Signed at Request of M.F.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1956		22c. NAME OF CEMETERY OR CREMATORY Pleasant Rest		22d. LOCATION (City, town, or county) (State) Towson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones 1631 Druid Hill Ave.				24a. REC'D BY REGISTRAR Nov. 5, 1956		24b. REGISTRAR'S SIGNATURE Harold M. Rags	

MEDICAL CERTIFICATION

Journal of Interpersonal Violence

BUREAU V. S.

NOV 5 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG208 12-12-56 et

CERTIFICATE OF DEATH

11054

Reg. Dist. No.

11073

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1122 Arran Road		d. STREET ADDRESS 1122 Arran Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clarence Raymond Kapp		4. DATE OF DEATH November 27/56 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7 1883
9. AGE (In years last birthday) 72 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rail road Engineer ret		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Isreal S Kapp		14. MOTHER'S MAIDEN NAME Catherine Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT C Raymond Kapp 1122 Arran Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 56 , to November , 19 56 , that I last saw the deceased alive on Nov 26 , 19 56 , and that death occurred at 2:30 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. F. Palmisano		M.D. 6014 Loch Raven Blvd 11/29/56	
PHYSICIAN'S NAME (Type) J. F. PALMISANO M.D.		Baltimore 12, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Nov 30/56	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road		ADDRESS	
24a. REC'D BY REGISTRAR NOV 29 1956		24b. REGISTRAR'S SIGNATURE Mark Gray	

CERTIFICATE OF DEATH

PLACE OF BIRTH COUNTY STATE		PLACE OF DEATH COUNTY STATE	
DATE OF BIRTH MONTH DAY YEAR		DATE OF DEATH MONTH DAY YEAR	
SEX MALE FEMALE		RACE WHITE NEGRO	
OCCUPATION TRADE PROFESSION		CAUSE OF DEATH (To be filled in by physician or coroner) 1. _____ 2. _____ 3. _____	
MANNER OF DEATH (To be filled in by physician or coroner) 1. _____ 2. _____ 3. _____		SIGNATURE OF PHYSICIAN OR CORONER _____ TITLE _____	
SIGNATURE OF REGISTRAR _____ TITLE _____		SIGNATURE OF WITNESS _____ TITLE _____	

BUREAU V. S.

NOV 29 1956

RECEIVED

11074

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
c. LENGTH OF STAY IN 1b <u>Lifetime</u>				d. STREET ADDRESS <u>14 Walker Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>— 14 Walker Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anna M. Kehoe</u>			4. DATE OF DEATH <u>Nov 28 1956</u>			Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9 1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Lapp</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Knight</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Arthur C. Kelly</u>		Address <u>Bally, Md. 225 Dundalk Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>5 years.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>30 Apr 1953</u> , to <u>28 Nov 1956</u> , that I last saw the deceased alive on <u>27 Nov 1956</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H Royse</u>				ADDRESS (Street, city or town, state) <u>808 Reisterstown Rd</u>			
PHYSICIAN'S NAME (Type) <u>Paul H Royse M.D.</u>				DATE SIGNED <u>28 Nov 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 30 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wood Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>				ADDRESS <u>Pikesville</u>		24a. REC'D BY REGISTRAR <u>DEC 3 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Dorothy Howell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

2nd 5th 10th

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESS</p>		<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CORONER</p>		<p>15. SIGNATURE OF JUDGE</p>	
<p>16. SIGNATURE OF CLERK</p>		<p>17. SIGNATURE OF REGISTRAR</p>		<p>18. SIGNATURE OF SHERIFF</p>		<p>19. SIGNATURE OF SHERIFF'S CLERK</p>		<p>20. SIGNATURE OF SHERIFF'S DEPUTY</p>	

BUREAU V. 3

DEC 3 1956

RECEIVED

11075 CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE	
c. LENGTH OF STAY IN 1b 32 years		d. STREET ADDRESS 2948 Edgewood Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2948 Edgewood Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First M. Middle Keller Last		4. DATE OF DEATH Nov 4 1956 Month Nov Day 4 Year 1956	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 21-1884 9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY AT Home	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter Koss	
14. MOTHER'S MAIDEN NAME MARY Andre		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mary Knepper Address 2948 Edgewood Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypert. Arteriosclerotic. Card. Vasc. Dis. DUE TO (c) Massive Silent Coronary Thromb.			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour 7+ yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Nov Day 4 Year 1956 Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 1 , 19 56 , to Nov 4 , 19 56 , that I last saw the deceased alive on Nov 4 , 19 56 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank T. Kasik M.D.		ADDRESS (Street, city or town, state) 9005 Hartford Rd DATE SIGNED 11/4/56	
PHYSICIAN'S NAME (Type) FRANK T. KASIK JR. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov. 7 - 1956	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	22d. LOCATION (City, town, or county) (State) BALTO MD
23. FUNERAL DIRECTOR'S SIGNATURE Chas F Evanson Sm.		24a. REC'D BY REGISTRAR Nov 5 1956 24b. REGISTRAR'S SIGNATURE Dr. A. M. Bascom	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race	
4. Date of Birth		5. Date of Death		6. Place of Birth	
7. Usual Residence		8. Cause of Death		9. Manner of Death	
10. Signature of Physician		11. Signature of Registrar		12. Signature of Coroner	
13. Date of Report		14. Time of Report		15. Name of Hospital	
16. Name of Doctor		17. Name of Nurse		18. Name of Undertaker	
19. Name of Burial Place		20. Name of Cemetery		21. Name of Funeral Home	
22. Name of Family		23. Name of Friends		24. Name of Neighbors	
25. Name of Relatives		26. Name of Friends		27. Name of Neighbors	
28. Name of Relatives		29. Name of Friends		30. Name of Neighbors	
31. Name of Relatives		32. Name of Friends		33. Name of Neighbors	
34. Name of Relatives		35. Name of Friends		36. Name of Neighbors	
37. Name of Relatives		38. Name of Friends		39. Name of Neighbors	
40. Name of Relatives		41. Name of Friends		42. Name of Neighbors	
43. Name of Relatives		44. Name of Friends		45. Name of Neighbors	
46. Name of Relatives		47. Name of Friends		48. Name of Neighbors	
49. Name of Relatives		50. Name of Friends		51. Name of Neighbors	
52. Name of Relatives		53. Name of Friends		54. Name of Neighbors	
55. Name of Relatives		56. Name of Friends		57. Name of Neighbors	
58. Name of Relatives		59. Name of Friends		60. Name of Neighbors	
61. Name of Relatives		62. Name of Friends		63. Name of Neighbors	
64. Name of Relatives		65. Name of Friends		66. Name of Neighbors	
67. Name of Relatives		68. Name of Friends		69. Name of Neighbors	
70. Name of Relatives		71. Name of Friends		72. Name of Neighbors	
73. Name of Relatives		74. Name of Friends		75. Name of Neighbors	
76. Name of Relatives		77. Name of Friends		78. Name of Neighbors	
79. Name of Relatives		80. Name of Friends		81. Name of Neighbors	
82. Name of Relatives		83. Name of Friends		84. Name of Neighbors	
85. Name of Relatives		86. Name of Friends		87. Name of Neighbors	
88. Name of Relatives		89. Name of Friends		90. Name of Neighbors	
91. Name of Relatives		92. Name of Friends		93. Name of Neighbors	
94. Name of Relatives		95. Name of Friends		96. Name of Neighbors	
97. Name of Relatives		98. Name of Friends		99. Name of Neighbors	
100. Name of Relatives		101. Name of Friends		102. Name of Neighbors	

RECEIVED
OCT 2 1956
BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11076

CERTIFICATE OF DEATH

11057

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>18 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Annice</u> First <u>Kendall</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Allen MacDonald</u>		14. MOTHER'S MAIDEN NAME <u>Marjorie Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Spring Grove Hosp.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conjunctive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema - Psychosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>May 27, 1938</u> to <u>Nov. 17, 1956</u> that I last saw the deceased alive on <u>Nov. 17, 1956</u> and that death occurred at <u>11:40 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Charles Ward</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove Hosp - 11/18/56</u>	
DATE SIGNED		PHYSICIAN'S NAME (Type) <u>DR. CHARLES WARD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-21-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE 11-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Victor C. Harry</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED [REDACTED]		DATE OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		CITY OF DEATH [REDACTED]	
AGE [REDACTED]		SEX [REDACTED]	
RACE [REDACTED]		MARRIAGE [REDACTED]	
OCCUPATION [REDACTED]		EDUCATION [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]	
DATE [REDACTED]		PLACE [REDACTED]	

REAU V. S.

OV 21 1956

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RECEIVED
MAY 21 1956
BALTIMORE
STATE DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11077

CERTIFICATE OF DEATH

11058

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> <u>Life</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5429 Whitlock Rd</u>				d. STREET ADDRESS <u>5429 Whitlock Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>A.</u> Last <u>Kernan Sr.</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1902</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John J. Kernan</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Caten</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Edna M. Kernan, 5429 Whitlock Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>296 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombocytopenia Purpura</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Splenectomy 2 yrs ago.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/4 hour</u> <u>2 1/2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>ch</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug.</u> , 19 <u>54</u> , to <u>Nov. 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 6</u> , 19 <u>56</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>11/8/56</u>							
ACTUAL SIGNATURE <u>m. j. mcdermott</u> M.D.				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Harry H. Witzke, 4101 Edmondson Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Harry</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>NEW YORK</i>		5. DATE OF BIRTH <i>1911</i>		6. PLACE OF DEATH <i>BALTIMORE</i>	
7. OCCUPATION <i>CLERK</i>		8. CAUSE OF DEATH <i>HEART DISEASE</i>		9. MANNER OF DEATH <i>NATURAL</i>	
10. DATE OF DEATH <i>NOV 13 1956</i>		11. TIME OF DEATH <i>10:30 AM</i>		12. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
13. SIGNATURE OF REGISTRAR <i>[Signature]</i>		14. SIGNATURE OF WITNESS <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	

BUREAU V. S.

NOV 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11078 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11059

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore #6</u>			
				d. STREET ADDRESS <u>1014 SUMTER</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Harry</u> Last <u>KERR</u>				4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1952</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 21-1940</u>	9. AGE (In years last birthday) <u>16</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High-School</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John D. KERR</u>				14. MOTHER'S MAIDEN NAME <u>BRAUCHMEYER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>219361701</u>		17. INFORMANT <u>PARENTS (SAME)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRANSECTION of Torso - Multiple</u> 902X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushing INJURIE - Struck</u> DUE TO (c) <u>by TRAIN</u> INSTANTANEOUS							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>9:30</u> a.m. <u>11-8</u> 1952	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RR Track</u>	20f. City or town <u>Baltimore</u>	(County)	(State) <u>MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack C Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 10-1952</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		22d. LOCATION (City, town, or county) <u>BALTO. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly, Essex, Md</u>				24a. REC'D BY REGISTRAR <u>NOV 13 1952</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. A. S. Poffenbarger</u>	

BUREAU V. S.

NOV 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11060

11079

CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Falls</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Falls</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Upper Falls</u>				d. STREET ADDRESS <u>Upper Falls</u>			
3. NAME OF DECEASED (Type or print) <u>CAROLINE</u> First <u>BLANCHE</u> Middle <u>KEYSER</u> Last				4. DATE OF DEATH <u>Nov.</u> Month <u>1</u> Day <u>1956</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 18 1864</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Crown Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Beale Rumsey</u>			
14. MOTHER'S MAIDEN NAME <u>Frances H Evans</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>			
16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>Matt Howard Rumsey</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>20 yrs.</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. n. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Oct.</u> <u>1955</u> , to <u>Oct.</u> <u>1956</u> , that I last saw the deceased alive on <u>Oct. 15</u> , 1956, and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>				DATE SIGNED <u>Nov. 2, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 5, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Kingsville, Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd.</u>				24a. REC'D BY REGISTRAR <u>Nov 7 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Walter H. Harnett</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11080

CERTIFICATE OF DEATH

11061

Reg. Dist. No.

31

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BAKTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN-</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BRIARSTONE RD -</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EVELYN</u> Middle <u>Considine</u> Last <u>KIRBY</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 6 - 1906</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME MAKER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>JOHN CONSIDINE</u>			
14. MOTHER'S MAIDEN NAME <u>SADYEA SHIPLEY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>219-30-0524</u>				17. INFORMANT Address <u>MRTAOS. KIRBY - BRIARSTONE RD - RANDALLSTOWN MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA BREAST & METASTASIS</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>TO SPINE - CERVICAL & THORACIC.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 YEARS</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>APRIL 1, 1956</u> , to <u>NOV. 6, 1956</u> ; that I last saw the deceased alive on <u>NOV. 6, 1956</u> , and that death occurred at <u>9:10</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>				ADDRESS (Street, city or town, state) <u>3601 CHEMAR RD - BAKTO 7 - MD.</u>			
DATE SIGNED <u>11/6/56</u>							
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>				ADDRESS <u>3601 CHEMAR RD - BAKTO 7 - MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thm. J. Siskner & Sons - Bacto 17, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Nov. 7, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. Thm. E. Martin</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MAYLAND		25		M		W		1930		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
11/11/56		10:00 AM		HOME		BALTIMORE		BALTIMORE		BALTIMORE		11/11/56		10:00 AM		HOME	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED	
CONSIDINE		NATURAL		N/A		N/A		N/A		N/A		N/A		N/A		N/A	
DISEASE		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS	
N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		SIGNATURE OF WITNESS		DATE OF SIGNATURE		SIGNATURE OF DECEASED		DATE OF SIGNATURE		SIGNATURE OF DECEASED		DATE OF SIGNATURE		SIGNATURE OF DECEASED	
N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A	

BUREAU V. S.

NOV 9 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE ST. HOSP		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MONKTON	
3. NAME OF DECEASED (Type or print) First Middle Last MARY CATHERINE KIRBY		4. DATE OF DEATH Month Day Year 11 / 26 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 / 21 / 1887
9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPING		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM KIRBY		14. MOTHER'S MAIDEN NAME ANNA KIRBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obliterative pericarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infarctive myocardial fibrosis DUE TO (c) Arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 2 , 1952 to Nov 26 , 1956, that I last saw the deceased alive on Nov. 26 , 1956, and that death occurred at 9:57 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Isadore Tuerk		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 11-27-56	
PHYSICIAN'S NAME (Type) Isadore Tuerk, M. D. Superintendent		Catonville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-29-56	22c. NAME OF CEMETERY OR CREMATORY St. James	22d. LOCATION (City, town, or county) (State) Monkton MD
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks		24a. REC'D BY REGISTRAR DATE 11/29/56	
ADDRESS Sparks, Md		24b. REGISTRAR'S SIGNATURE V.E. Harry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mostly illegible due to blurriness.

BUREAU V. S.

NOV 30 1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film 207 11-19-56 et

CERTIFICATE OF DEATH

11063

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 231 Dumbarton Rd.				d. STREET ADDRESS 231 Dumbarton Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNA Middle M. Last KISER				4. DATE OF DEATH Month Nov. Day 7 Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 11, 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? -							
13. FATHER'S NAME John W. (last name unknown)				14. MOTHER'S MAIDEN NAME Mary Whitman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. no		17. INFORMANT Mr. LeRoy Kiser - 231 Dumbarton Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 6 , 19 56 , to Nov 7 , 19 56 , that I last saw the deceased alive on Nov 7 , 19 56 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd. Baltimore 12, Md DATE SIGNED 11-8-56							
ACTUAL SIGNATURE Laurence C. Post M.D.							
PHYSICIAN'S NAME (Type) LAURENCE C. POST							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/56		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner				24a. REC'D BY REGISTRAR Nov 13, 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

RECEIVED

NOV 14 1956

BUREAU V. S.

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form
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VS. A15ME1
SM 9/55

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any
with file, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the fune
the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for ya
NOTOR: Page 3 should be read as a burial certificate.

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or. Page should be

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11064

11083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Belt</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 97 Poplar Rd Cedar Beach</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Milton M Knapp</u>				4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/19/1896</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>MORITZ KNAPP</u>				14. MOTHER'S MAIDEN NAME <u>CHRISTINA ZORN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.I.</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>ETTA M KNAPP</u>				Address <u>SAME AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>6 yrs</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J Connelly</u>				ADDRESS <u>418 Eastern Ave.</u>		24a. REC'D BY REGISTRAR <u>Mr Kelly</u>	
				DATE <u>NOV 14 1956</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DATE SIGNED

11-12-56

Casey 21-mb.

1007 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. S.

NOV 14 1952

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11065

11084

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>66 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>6911 Railway Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>KONDRAT</u> Middle <u>(Also: KOMISAR) (NMI)</u> Last <u>KOMIZAR</u>				4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/10/95</u>	
9. AGE (In years last birthday) <u>61 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A?</u>							
13. FATHER'S NAME <u>Nicholi Komizar</u>				14. MOTHER'S MAIDEN NAME <u>Taklia MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If yes, give war or dates of service) <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>213 09 3164</u>		17. INFORMANT <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF ESOPHAGUS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>September 24, 1956</u> , to <u>November 29, 1956</u> , that I last saw the deceased alive on <u>November 29, 1956</u> and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Maryland</u> DATE SIGNED <u>11/30/56</u>							
ACTUAL SIGNATURE <u>Francis G. Dickey</u> M.D.				PHYSICIAN'S NAME (Type) <u>FRANCIS G. DICKEY, M.D., Chief, Medical Service</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>DEC 3 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY TRINITY CEM. Baltimore, Maryland</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dippel Brothers, Inc., 1800 E. Lombard, Balto., Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 3 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Furler</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11066

11085

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 11 Hrs. 40 M.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. STREET ADDRESS 1828 Alice Anne Street			
3. NAME OF DECEASED (Type or print) (Also: WIKTON S. & VIKTON S. (MM) VIKTOR S. KULIKOSKI)				4. DATE OF DEATH Month November Day 11 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/94	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Maker		10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair		11. BIRTHPLACE (State or foreign country) Lubin, Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Leo Kulikoski				14. MOTHER'S MAIDEN NAME Stella			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-01-9182		17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Biliary cirrhosis 2. Stone in common bile duct. 3. Arteriosclerotic heart disease							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from November 11, 1956 , to November 11, 1956 , and that death occurred at 11:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. J. PAPA				ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland		DATE SIGNED 11/13/56	
PHYSICIAN'S NAME (Type) C. J. PAPA				ADDRESS VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-16-56	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight				24a. REC'D BY REGISTRAR DATE 11-23-56		24b. REGISTRAR'S SIGNATURE W. D. Dawson	

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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BUREAU V. S.

1956

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11067

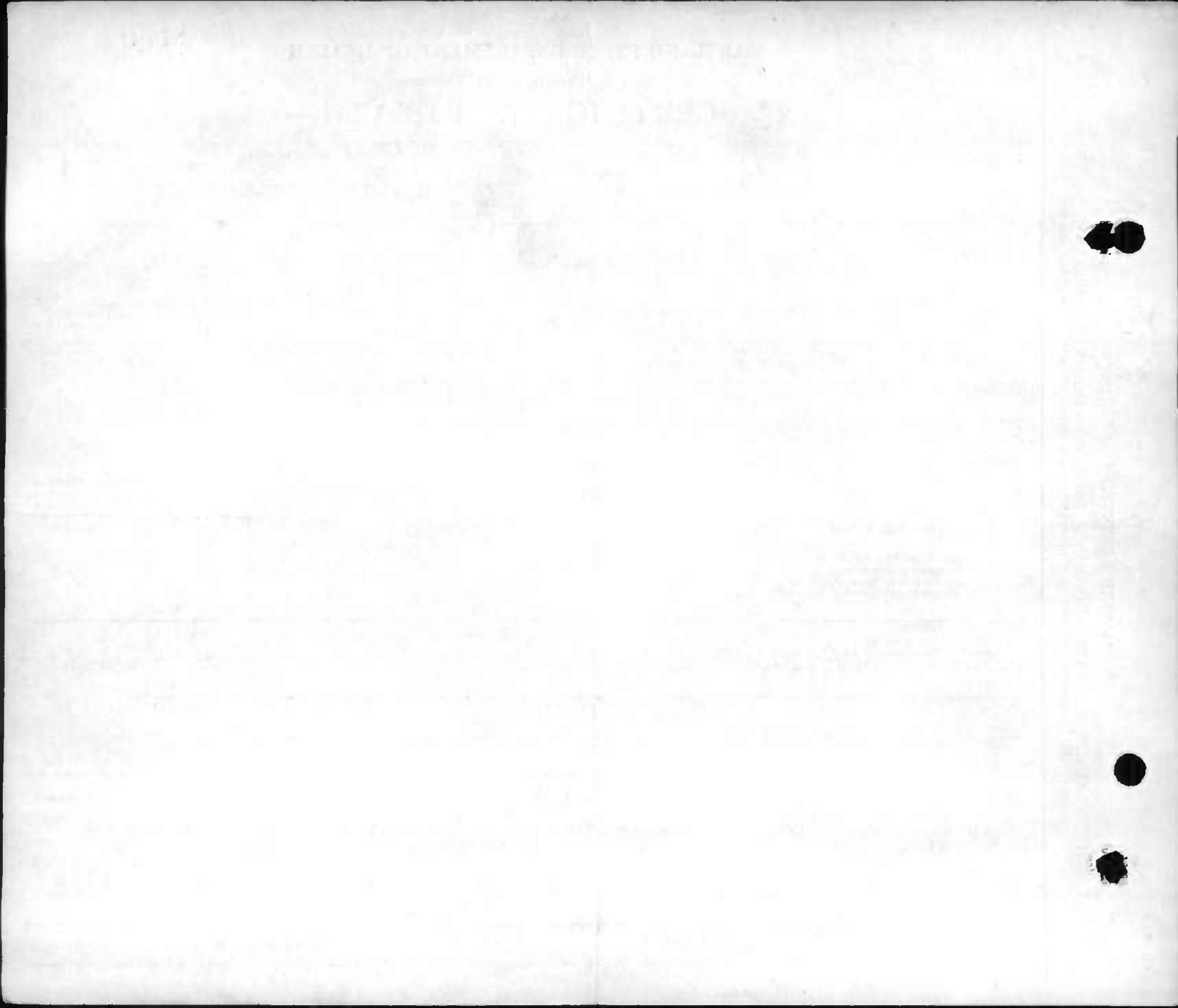
11086

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u> LENGTH OF STAY (in this place) <u>6 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE Co.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2111 Valethorn Road</u>		STREET ADDRESS (If rural give location) <u>2111 VALETHORN Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Arthur</u>	(First) <u>Arthur</u>	(Middle) <u>Landon</u>	(Last)
4. DATE OF DEATH <u>Nov 18</u>	(Month) <u>Nov</u>	(Day) <u>18</u>	(Year) <u>1956</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-7-1882</u>
9. AGE last birthday <u>74</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>CRISFIELD - MD</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN LANDON</u>		14. MOTHER'S MAIDEN NAME <u>THOMPAS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>218-01-2384</u>	
17. INFORMANT <u>MRS. CARRIE LANDON 2111 Valethorn Rd</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) <u>Myocardial Infarction</u>		<u>3 days</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Coronary Arteriosclerosis</u>		<u>10 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased (from....., 19....., to....., 19.....) that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.			
SIGNATURE <u>David A. Levy M.D.</u>		DATE SIGNED <u>Nov 18, 1956</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem Park</u>	
DATE REC'D BY LOCAL REG <u>11/20/56</u>		24. FUNERAL DIRECTOR <u>Thomas J. Kenny Inc - 1600 Hillis St</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10973 CERTIFICATE OF DEATH

11068

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 711 Aldworth Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alfred J Lentz First Middle Last		4. DATE OF DEATH Nov 1 1956 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 18 1908
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver		10b. KIND OF BUSINESS OR INDUSTRY Shell Trucking Co	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Louis J Lentz		14. MOTHER'S MAIDEN NAME Catherine Kowling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW 2		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles V Lentz Address 711 Aldworth Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary Vessel Sclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH approx 27 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/2/36 19, to 11/2/56 19, that I last saw the deceased alive on 11/2/56 19, and that death occurred at 6:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Osvaldo Benier M.D. 10/3/56		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) OSVALDO BERRIER MD Balto. Md.		This pt. was seen at home 5 pm - died at approx 6:45 PM	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Nov 5/56	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave ADDRESS		24a. REC'D BY REGISTRAR NOV 8 1956 DATE	
		24b. REGISTRAR'S SIGNATURE Wm. M. Kelly Jr.	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. OCCUPATION [Illegible]</p>	
<p>7. MARITAL STATUS [Illegible]</p>		<p>8. CAUSE OF DEATH [Illegible]</p>	
<p>9. MANNER OF DEATH [Illegible]</p>		<p>10. PLACE OF DEATH [Illegible]</p>	
<p>11. DATE OF DEATH [Illegible]</p>		<p>12. TIME OF DEATH [Illegible]</p>	
<p>13. SIGNATURE OF DECEASED [Illegible]</p>		<p>14. SIGNATURE OF WITNESS [Illegible]</p>	
<p>15. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>16. SIGNATURE OF CORONER [Illegible]</p>	
<p>17. SIGNATURE OF REGISTRAR [Illegible]</p>		<p>18. SIGNATURE OF CLERK [Illegible]</p>	

BUREAU V. S.

NOV 8 1956

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CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>			
c. LENGTH OF STAY IN 1b <u>34 yrs.</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1017 RoseDAle Ave.</u>				d. STREET ADDRESS <u>1017 RoseDAle Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Jacob</u> Last <u>LEVY</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1881</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Distillery man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Distillery Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Vaclav Levy</u>				14. MOTHER'S MAIDEN NAME <u>Antoine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-066</u>		17. INFORMANT Address <u>Josephine Levy 1017 RoseDAle Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED, While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>Nov. 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 6</u> , 19 <u>56</u> , and that death occurred at <u>8:25</u> PM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>James R. Mason, M.D.</u> M.D.				<u>8019 Philadelphia Rd.</u> <u>Nov. 7, 1956</u>			
PHYSICIAN'S NAME (Type) <u>James R. Mason, M. D.</u>				<u>Baltimore 6, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Philip F. Goch 2716 E. Monument St.</u>				24a. REC'D BY REGISTRAR DATE <u>Nov. 8, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

3561 6 NOV

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11088

CERTIFICATE OF DEATH

1107038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1005 Malvern Ave</u>		d. STREET ADDRESS <u>1005 Malvern Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Janet Gordon Lewin</u> First Middle Last		4. DATE OF DEATH <u>11</u> <u>9</u> <u>1956</u> Month Day Year	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 11 1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE (In years last birthday) <u>46</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Baeto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr Albert Keidel</u>		14. MOTHER'S MAIDEN NAME <u>Janett Gordon Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>John Henry Lewin</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153x</u> DUE TO <u>Carcinoma of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>4 yr.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 7th</u> 1956, to <u>Nov.</u> 1956, that I last saw the deceased alive on <u>Nov. 7th</u> 1956, and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Murray Fisher</u> M.D.		ADDRESS (Street, city or town, state) <u>18 E. Eager St. Baltimore - 2. Md.</u> DATE SIGNED <u>11/9/56</u>	
PHYSICIAN'S NAME (Type) <u>A Murray Fisher</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 12 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	22d. LOCATION (City, town, or county) (State) <u>Baeto, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Harkins & Sons Co</u> ADDRESS <u>4905 York Rd</u>		24a. REC'D BY REGISTRAR <u>NOV 13 1956</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10974 CERTIFICATE OF DEATH

11071 41

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>3426 LOUTH RD.</u>	
3. NAME OF DECEASED (Type or print) <u>LEWIS</u> <u>FIRST</u> <u>MIDDLE</u> <u>MITTIE</u> <u>JENKINS</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>86</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MATE JENKINS</u>		14. MOTHER'S MAIDEN NAME <u>MARY CRAWFORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. FLOSSY BROOKS (DAUGHTER)</u>		Address <u>3426 LOUTH RD. DUNDALK, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>7 YRS.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>22-NOV</u> , 19 <u>56</u> , to <u>23-NOV</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>22 NOV</u> , 19 <u>56</u> , and that death occurred at <u>3:00 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W E Baermann</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>DR. W. E. BAERMANN</u> <u>33 DUNDALK AVENUE</u> <u>DUNDALK 22, MARYLAND</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. CO, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bradley, Dundalk, MD</u>		24a. REC'D. BY REGISTRAR DATE <u>NOV 28 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Mr. Kelly</u>

BUREAU A. S.

NOV 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11072 44

11089 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BA</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>22 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>5820 Ritchie Highway</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>C.</u> Last <u>LINTHICUM</u>				4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/19/99</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>New York, New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John C. Linthicum</u>				14. MOTHER'S MAIDEN NAME <u>Helen Perry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>549 18 6624</u>		17. INFORMANT <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TO LUNGS AND NECK</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>161X</u>				CARCINOMA OF LARYNX WITH METASTASIS INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 2, 1956</u> , to <u>November 24, 1956</u> , that he was alive on <u>November 24, 1956</u> , and that death occurred at <u>3:25 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>11/24/56</u>							
ACTUAL SIGNATURE <u>James J. Nolan</u>				PHYSICIAN'S NAME (Type) <u>JAMES J. NOLAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Ritchie Highway Baltimore, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Nolan</u> ADDRESS <u>128 E. Fort Ave. Baltimore, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>11/27/1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farber</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

BUREAU V. S.

NOV 27 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 FilmG207 11-20-56 et
11090
CERTIFICATE OF DEATH

11073
45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7701 Belair Rd.		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River Baltimore 6		d. STREET ADDRESS 4126 Grape Hill Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Percival Middle ✓ Last Long		4. DATE OF DEATH Month 11/9/56 Day 1956 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1886
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad		10b. KIND OF BUSINESS OR INDUSTRY Penn.	
11. BIRTHPLACE (State or foreign country) Alburton, Howard Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Daniel Long		14. MOTHER'S MAIDEN NAME Hettie W. Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 717-07-7026	
17. INFORMANT Chester Schaffer		Address 4126 Grape Hill Rd. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Squamous Cell Carcinoma of Larynx		INTERVAL BETWEEN ONSET AND DEATH 1 YR	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , to 1956 , that I last saw the deceased alive on NOVEMBER 8, 1956 , and that death occurred at 7:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harvey L. Fuller M.D.		ADDRESS (Street, city or town, state) RIDGE RD. BALTIMORE 6, MD	
PHYSICIAN'S NAME (Type) HARVEY L. FULLER, M.D.		DATE SIGNED 11/13/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/56	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikrsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sassa Funeral Home		ADDRESS 7401 Belair rd. 6	
24a. REC'D BY REGISTRAR NOV 13 1956		24b. REGISTRAR'S SIGNATURE Edith Hurley	

RECEIVED
NOV 18 1956
BUREAU V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11091 CERTIFICATE OF DEATH

11074

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1422 N. Gay Street	
3. NAME OF DECEASED (Type or print) First JAMES Middle L. Last LUCAS		4. DATE OF DEATH Month November Day 17 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/13
9. AGE (In years lost birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Spring Hope, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Grover Lucas		14. MOTHER'S MAIDEN NAME Joney May Langley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 237-10-8964	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 592x DUE TO CHRONIC GLOMERULONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension due to chronic glomerulonephritis. 2. Cardiac enlargement		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS 10 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 29, 1956 to November 17, 1956 and that death occurred at 2:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. J. Papastrat M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 11/19/56	
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.		M.D. VAH, FORT HOWARD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/21/56	
22c. NAME OF CEMETERY OR CREMATORY Keyville Cemetery		22d. LOCATION (City, town, or county) (State) Washington, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802-04 Madison Ave.		24a. REC'D BY REGISTRAR 11/21/56	
24b. REGISTRAR'S SIGNATURE Dawson L. Torrey			

Shipped To: Leon Randolph, Jr., Washington, N. Carolina

RECEIVED
NOV 26 1956
BUREAU V. I.

NOV 26 1956

11092 CERTIFICATE OF DEATH

11075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Syracuse Cal</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Syracuse Cal</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Augustsburg Home</u>				d. STREET ADDRESS <u>6711 Campfield Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mary Ann Lutz</u> First Middle Last				4. DATE OF DEATH <u>Nov 13</u> Year <u>1956</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 24 1873</u> yrs. <u>83</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>York Pa</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm R Lutz</u>				14. MOTHER'S MAIDEN NAME <u>Christiana Wilkerson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>8-</u>		17. INFORMANT <u>Kurows</u> Address <u>6711 Campfield Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arterio-sclerotic Cardio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vascular Disease</u> (c) <u>Senile Dementia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio-sclerosis</u> <u>5 yrs.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 2 -</u> , 19 <u>54</u> , to <u>11/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/8</u> , 19 <u>56</u> , and that death occurred at <u>11:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Chambers</u> M.D.				ADDRESS (Street, city or town, state) <u>4108 Liberty Hts Balto Md</u> DATE SIGNED <u>11-14-56</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers M. D. 4108 Liberty Heights Avenue Baltimore 7, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem</u>		22d. LOCATION (City, town, or county) (State) <u>York Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Deleuane</u> ADDRESS <u>Harford Rd</u>				24a. REC'D BY REGISTRAR <u>NOV 20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Martens</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 20 1956

REGISTRATION

11093 CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>				c. LENGTH OF STAY IN 1b <u>86 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>Baldwin</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence May MacCubbin</u>				4. DATE OF DEATH Month Day Year <u>Nov 7 1956 19</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5th 1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baldwin Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John T MacCubbin</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Watkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>John MacCubbin Baldwin Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>545X</u> DUE TO <u>Inanition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Duodenal scarring</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 13, 1954</u> to <u>Nov. 7, 1956</u> that I last saw the deceased alive on <u>Oct. 13, 1956</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>11-8-56</u>			
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Sweet Air Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion Ruth Jewett</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>11-9-56</u>		24b. REGISTRAR'S SIGNATURE <u>W M Hammett</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

John T. McLaughlin
M.D.
1956

John T. McLaughlin
1956
John T. McLaughlin
1956
John T. McLaughlin
1956

John T. McLaughlin
1956
John T. McLaughlin
1956
John T. McLaughlin
1956

BUREAU V. S.

DEC 23 1956

RECEIVED

John T. McLaughlin
1956
John T. McLaughlin
1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11094

CERTIFICATE OF DEATH

11076

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 175 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1810 California Street, N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DONALD Middle (NMI) Last MACK		4. DATE OF DEATH Month November Day 19 Year 19 56					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 14, 1910	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Boiler- Steel Co.		11. BIRTHPLACE (State or foreign country) Charles County, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Mack				14. MOTHER'S MAIDEN NAME Hettie MN: Miles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW II (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-09-5599		17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LEFT UPPER LOBE OF LUNG WITH METASTASES 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 28, 1956 , to November 19, 1956 , and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 11/20/56							
ACTUAL SIGNATURE C. J. Papastrat M.D.		M.D. VAH, FORT HOWARD, MARYLAND					
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-26-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest Jarvis Funeral Home, Washington, D. C.				24a. REC'D BY REGISTRAR DEC 3 1956			
24b. REGISTRAR'S SIGNATURE Lawson L. Farber							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11001

THE DEPT. OF

PLACE OF BIRTH 1011 N. 1st St. Baltimore, Md.		DATE OF BIRTH 1910	
SEX Male		RACE White	
OCCUPATION Laborer		PLACE OF DEATH 1011 N. 1st St. Baltimore, Md.	
DATE OF DEATH 1910		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH 1. 2. 3.		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. J. [Signature]		SIGNATURE OF REGISTRAR [Signature]	
COUNTY Baltimore		CITY Baltimore	
STATE Maryland		DISTRICT 1	

JREAU V. 3

DEC 3 1910

RECEIVED

10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12186		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.		
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>8000 Eastern Ave.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Allen MADISON</u>					4. DATE OF DEATH Month Day Year <u>11 17 19 56</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>64 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive CARDIOVASCULAR Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. <u>322.1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u>										INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>Jack C. Collins</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED		
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					11-17-56		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Embalmed</u>			22b. DATE THEREOF <u>12-11-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Univ. of Md. Med. School</u>			22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE					
					DEC 18 '56		<u>Outreach</u>					

1313
 MARYLAND STATE DEPARTMENT OF HEALTH-CERTIFICATE OF DEATH
 MEDICAL EXAMINEE'S CERTIFICATE OF DEATH

11102

BUREAU V. 5

DEC 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11077

11095

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loch Raven Village				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loch Raven Village			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8352 Loch Raven Blvd.				d. STREET ADDRESS 8352 Loch Raven Blvd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CHARLES Middle J. Last MALCHODI				4. DATE OF DEATH Month Nov. Day 13 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 27, 1892	
9. AGE (In years last birthday) 64 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Worker		10b. KIND OF BUSINESS OR INDUSTRY Cement		11. BIRTHPLACE (State or foreign country) N. Y.	
13. FATHER'S NAME Adolph Malchodi				14. MOTHER'S MAIDEN NAME Virginia (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mr. Ernest Malchodi - 1622 Hardwick Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 4 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 13, 1956 , to Nov. 13, 1956 , that I last saw the deceased alive on Nov. 12, 1956 , and that death occurred at 3 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph F. Li Pira M.D.				ADDRESS (Street, city or town, state) 8400 Loch Raven Blvd, BALTO, Md.			
PHYSICIAN'S NAME (Type) JOSEPH F. LI PIRA				DATE SIGNED 4, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/56		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thm. J. Tiekner & Sons - Balto 17, Md.				24a. REC'D BY REGISTRAR DATE Nov. 14, 1956		24b. REGISTRAR'S SIGNATURE Dr. H. M. Bacon	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11078

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryl.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Capensville</u>	c. LENGTH OF STAY IN 1b <u>22 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hosp.</u>		d. STREET ADDRESS <u>324 S. Augusta Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine T. Malone</u> First Middle Last	4. DATE OF DEATH <u>11-18-1956</u> Month Day Year		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 12-1869</u> 9. AGE (In years last birthday) <u>87</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRESS MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (State or foreign country) <u>Howard Co., Md</u>
13. FATHER'S NAME <u>Edward Malone</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Fitzpatrick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Spring Grove Hosp.</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 22, 1934</u> to <u>Nov. 18, 1956</u> that I last saw the deceased alive on <u>Nov. 18, 1956</u> and that death occurred at <u>5:05 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Ward</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove Hosp.</u> DATE SIGNED <u>11/18/56</u>	
PHYSICIAN'S NAME (Type) <u>DR. CHARLES WARD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov. 19, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. H. Walters</u> ADDRESS <u>1111 N. E. St.</u>		24a. REC'D BY REGISTRAR <u>NOV 20 1956</u> DATE	24b. REGISTRAR'S SIGNATURE <u>T. E. Harris</u>

BUREAU V. 8

1956 20 NOV

RECEIVED

11098 CERTIFICATE OF DEATH

Reg. Dist. No. 11079

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1318 Pine Grove Avenue		d. STREET ADDRESS 1318 Pine Grove Avenue	
3. NAME OF DECEASED (Type or print) First Josiah Middle Gooding Last Massey		4. DATE OF DEATH Month November Day 20 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 24, 1906
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer		10b. KIND OF BUSINESS OR INDUSTRY Walsh Constr. Co.	
11. BIRTHPLACE (State or foreign country) Chestertown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josiah A. Massey		14. MOTHER'S MAIDEN NAME Helen Gooding	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-09-0374	
17. INFORMANT Clara Debelius Massey, wife, above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular disease DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 20, 1956 to Nov 20, 1956 that I last saw the deceased alive on Nov 20, 1956 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. M. Baumgardner M.D.		DATE SIGNED 11/20/56	
PHYSICIAN'S NAME (Type) G. M. Baumgardner, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23, 1956	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schimmek Funeral Home, Inc. 2601 E. Madison St.		24a. REC'D BY REGISTRAR DATE 11-21-56	
24b. REGISTRAR'S SIGNATURE Edith Hurley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11099 CERTIFICATE OF DEATH

Reg. Dist. No. 11080 44

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 144 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle M. Last MC LIN		4. DATE OF DEATH Month November Day 26 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1889
9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Logan, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew McLin		14. MOTHER'S MAIDEN NAME Sarah Knott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give war or dates of service WW I		16. SOCIAL SECURITY NO. 217-18-5159	
17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE ESOPHAGUS WITH METASTASES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 3, 19 56 , to November 26, 19 56 , and that death occurred at 1:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE C. J. Papastrat M.D.		VETERANS ADMINISTRATION HOSPITAL 11/27/56	
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.		Fort Howard, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		ADDRESS 6009 Harford Rd., Balto. 14, Md.	
24a. REC'D BY REGISTRAR DEC 3 1956		24b. REGISTRAR'S SIGNATURE Lawson L. Farber	

CERTIFICATE OF DEATH

NAME OF DECEASED John Wilson		DATE OF BIRTH 1890		SEX Male		RACE White		MARRIAGE Married		OCCUPATION Carpenter	
PLACE OF BIRTH Maryland		DATE OF DEATH Dec 3, 1956		TIME OF DEATH 10:00 AM		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF DEATH Home	
FATHER'S NAME John Wilson		MOTHER'S NAME Mary Wilson		FATHER'S OCCUPATION Carpenter		MOTHER'S OCCUPATION Homemaker		FATHER'S PLACE OF BIRTH Maryland		MOTHER'S PLACE OF BIRTH Maryland	
DECEASED'S ADDRESS 123 Main St, Baltimore, MD		DECEASED'S AGE 66		DECEASED'S SEX Male		DECEASED'S RACE White		DECEASED'S MARRIAGE Married		DECEASED'S OCCUPATION Carpenter	
DECEASED'S DATE OF BIRTH 1890		DECEASED'S TIME OF BIRTH 10:00 AM		DECEASED'S CAUSE OF BIRTH Heart Disease		DECEASED'S MANNER OF BIRTH Natural		DECEASED'S PLACE OF BIRTH Maryland		DECEASED'S PLACE OF DEATH Home	
DECEASED'S FATHER'S NAME John Wilson		DECEASED'S MOTHER'S NAME Mary Wilson		DECEASED'S FATHER'S OCCUPATION Carpenter		DECEASED'S MOTHER'S OCCUPATION Homemaker		DECEASED'S FATHER'S PLACE OF BIRTH Maryland		DECEASED'S MOTHER'S PLACE OF BIRTH Maryland	
DECEASED'S ADDRESS 123 Main St, Baltimore, MD		DECEASED'S AGE 66		DECEASED'S SEX Male		DECEASED'S RACE White		DECEASED'S MARRIAGE Married		DECEASED'S OCCUPATION Carpenter	

BUREAU V. S.

DEC 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11100 CERTIFICATE OF DEATH

1108_h

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore, Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>938 S. Clinton Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>V.</u> Last <u>Meehan</u>		4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>19 56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Emma Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the rectum - colostomy</u>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 19, 19 53</u> , to <u>Nov. 12, 19 56</u> , that I last saw the deceased alive on <u>November 12 19 56</u> , and that death occurred at <u>6:30 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Stella Wachslar</u> M.D. <u>SPRING GROVE STATE HOSPITAL 11-13-56</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> <u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/16/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		24a. REC'D BY REGISTRAR <u>16 1956</u>	
ADDRESS <u>Balto. 21 - Md.</u>		24b. REGISTRAR'S SIGNATURE <u>V. C. Garry</u>	

REC'D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11101 CERTIFICATE OF DEATH

11082

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1004 W. 40th Street	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle A Last MEYER		4. DATE OF DEATH Month November Day 2 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 65 yrs.
11. BIRTHPLACE (State or foreign country) Cincinnati, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Meyer		14. MOTHER'S MAIDEN NAME Emma Keller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. 138 03 2628	
17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYDRONEPHROSIS 601x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 4, 19 56 , to November 2, 19 56 , that I lost the deceased NOV 56 and that death occurred at 7:30P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C.J. Papastrat M.D.		ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 11-3-56	
PHYSICIAN'S NAME (Type) C.J. PAPASTRAT		M.D. VAH, Fort Howard, Md. 11-3-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov 7, 1956	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Donovan Funeral Home, 3818 Roland Ave		24a. REC'D BY REGISTRAR DATE 11/5 1956	24b. REGISTRAR'S SIGNATURE Lawson L. Garber

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 5 10.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11102

CERTIFICATE OF DEATH

11083

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>1 mo, 27 d</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> <u>3-01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>3931 Clark Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Leonard</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>November</u> Day <u>4</u> Year <u>1956</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1879</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>56</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>;</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>;</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>Hyman Miller</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Miller</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records: Spring Grove State Hosp.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>56</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>Balto</u>				20g. (County) <u>md</u>		20h. (State) <u>md</u>			
21. I certify that I attended the deceased from <u>Oct. 18</u> , 19 <u>55</u> , to <u>Nov. 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 4</u> , 19 <u>56</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp.</u>					
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>				DATE SIGNED <u>11-4-1956</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11-5-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>			
22d. LOCATION (City, town, or county) <u>Balto</u>				22e. (State) <u>md</u>		22f. (State) <u>md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u>				ADDRESS <u>2100 Brittan Pl</u>		24a. REC'D BY REGISTRAR <u>NOV 7 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>J. B. Harris</u>									

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11084

Item / Film 6207 11-19-56 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER MD</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7-FERN PLACE</u>				e. STREET ADDRESS <u>7 FERN PLACE</u>			
3. NAME OF DECEASED (Type or print) First <u>MARIA</u> Middle <u>GRACE</u> Last <u>MORGAN</u>				4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 4 - 1906</u>	
9. AGE (in years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEL OPERATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.F. + G. CO</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>RICHARD HUGHES</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>21501-7312</u>		17. INFORMANT Address <u>RAYMOND MORGAN 7-FERN PLACE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PAK LA WIV</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blarney Hoffman</u>				ADDRESS <u>3218 Hudson St</u>		24a. REC'D BY REGISTRAR <u>NOV 14 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Barclay</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11104

CERTIFICATE OF DEATH

110858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2625 Wendover Road</u>		d. STREET ADDRESS <u>2625 Wendover Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. George L. (Pete) Moss</u>		4. DATE OF DEATH Month Day Year <u>November 20 19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20, 1903</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer Waverly Press</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Moss</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Schleifer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-07-0074</u>	
17. INFORMANT Address <u>Mrs. Dorothy M. Moss, 2625 Wendover Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Lungs</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Carcinoma of Esophagus</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 Month</u> <u>1 1/2 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 18, 1956</u> , to <u>November 19, 1956</u> , that I last saw the deceased alive on <u>November 8, 1956</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>7501 York Rd</u> DATE SIGNED <u>11/23/56</u>	
PHYSICIAN'S NAME (Type) <u>TOWSON #4 MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/24/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Hartford Road #14</u>		24a. REC'D BY REGISTRAR <u>NOV 26 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11105 CERTIFICATE OF DEATH

11086

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2115 Gwynn Oak Avenue		d. STREET ADDRESS 2115 Gwynn Oak Avenue	
3. NAME OF DECEASED (Type or print) First LOUISA Middle C. Last MULLINEAUX		4. DATE OF DEATH: Month November , Day 28 th, Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June, 25 1857
9. AGE (In years last birthday) 99 yrs.		IF UNDER 1 YEAR: Months 99 Days 99 Hours 99 Min. 99	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Baltimore, Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Loos		14. MOTHER'S MAIDEN NAME Catherine Steckell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Ruth Mullineaux		Address 2115 Gwynn Oak Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) None			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary artery disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT OR UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 56 p. m. None		20d. INJURY OCCURRED While at work <input type="checkbox"/> While not at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) None (County) (State)	
21. I certify that I attended the deceased from April 1948 to Nov. 28 1956 , that I last saw the deceased alive on Nov. 27 1956 , and that death occurred at 10:45 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Carl Myers		ADDRESS (Street, city or town, state) 1401 East Cold Spring Lane	
PHYSICIAN'S NAME (Type) J.C. Myers		DATE SIGNED M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 1 1956	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE B. Ellis Lamoreaux		24a. RECEIVED BY REGISTRAR DEC 3 1956	
ADDRESS 4510 Liberty Heights Avenue		24b. REGISTRAR'S SIGNATURE Mr. Wm. E. Martens	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1

DECEASED NAME JAMES EARL RAY		SEX Male		RACE White	
DATE OF BIRTH May 19, 1928		PLACE OF BIRTH Alton, Illinois		COUNTY OF BIRTH Madison	
DATE OF DEATH April 4, 1968		PLACE OF DEATH Memphis, Tennessee		COUNTY OF DEATH Shelby	
TIME OF DEATH 1:00 PM		CAUSE OF DEATH Gunshot wound		MANNER OF DEATH Homicide	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CORONER (None)		SIGNATURE OF JURY (None)		SIGNATURE OF STATE ATTORNEY (None)	
SIGNATURE OF DISTRICT ATTORNEY (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF REGISTRAR (None)	

BUREAU V. S.

DEC 3 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the office of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

11106 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11087	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 44	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balt</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt. 19</u>					c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 16</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>3029 Gwynns Falls Pkwy</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>E.</u> Last <u>MURPHY</u>					4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1956</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-27-96</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Mpnths Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Booby Operator</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT MURPHY</u>					14. MOTHER'S MAIDEN NAME <u>BETTY TUCK</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. <u>INFORMANT</u> <u>MRS. JOSIE E. MURPHY</u> <u>3029 Gwynns Falls Pkwy.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (c) <u>gave rise to immediate cause (a), stating the underlying cause lost.</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Jack C. Collins</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>11-22-56</u>	
EXAMINER'S NAME (Type) <u>JACK C. Collins</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>Nov. 26, '56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Cems.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>1631 Laurel Hill</u>					24a. REC'D BY REGISTRAR <u>NOV 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Lanberg</u>				

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Good woman, 40 years old, born in
 Mrs. Cecil E. Minkley
 BETTY L. L. 1915

Minkley, Mrs. Cecil E.

11

RECEIVED

NOV 26 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film 6208 11-15-56 et

11088

11107

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 2yrs		d. STREET ADDRESS 459 Brunswick St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennie Middle A. Last Pfeiffer Murphy		4. DATE OF DEATH Month November Day 8, Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1879
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Pfeiffer		14. MOTHER'S MAIDEN NAME Caroline Kesting	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 26, 1956 , to Nov. 8, 1956 , that I last saw the deceased alive on Nov. 8, 1956 , and that death occurred at 6:30a M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11-8-56	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 11-12-56	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR NOV 9 1956 24b. REGISTRAR'S SIGNATURE P. E. Harry	

RECEIVED

NOV 9 1956

BUREAU V. 3

MAYLAND STATE OF MARYLAND	
CERTIFICATE OF DEATH	
1956	
PLACE TO BE FILLED BY THE REGISTRAR	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. DATE OF DEATH	
7. PLACE OF DEATH	
8. CAUSE OF DEATH	
9. MANNER OF DEATH	
10. SIGNATURE OF REGISTRAR	
11. SIGNATURE OF DECEASED	
12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF FUNERAL HOME	
14. SIGNATURE OF MINISTER OF THE GOSPEL	
15. SIGNATURE OF CLERGYMAN	
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111108

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 5 FilmG207 11-26-56 et
CERTIFICATE OF DEATH

11089

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Baltimore				12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Arnacost Nursing Home-812 Register Ave				d. STREET ADDRESS 7106 Bristol Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle L. Last MURRELL		4. DATE OF DEATH Month Nov. Day 16, Year 19 56					
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1867	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (rtd)		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Hillen Harrell				14. MOTHER'S MAIDEN NAME Mary Louise Draper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Harry B. Lentz-7106 Bristol Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis 420.1 DUE TO Arterio Sclerotic Corded Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disease (c) Semility							INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 12 56 , 19____, to Nov 16 , 19____, that I last saw the deceased alive on Nov 16 , 19____, and that death occurred at 4 30 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE M Paul Byerly				ADDRESS (Street, city or town, state) 3033 W North St			
PHYSICIAN'S NAME (Type) M Paul Byerly				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Pickner & Sons - Balto.				24a. REC'D BY REGISTRAR NOV 19 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

CERTIFICATE OF DEATH

INSTITUTIONAL STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11113

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. COLOR [Illegible]		9. RELIGION [Illegible]	
10. DATE OF DEATH [Illegible]		11. PLACE OF DEATH [Illegible]		12. CAUSE OF DEATH [Illegible]	
13. MANNER OF DEATH [Illegible]		14. SIGNATURE OF PHYSICIAN [Illegible]		15. SIGNATURE OF REGISTRAR [Illegible]	
16. SIGNATURE OF WITNESS [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF NEXT OF KIN [Illegible]	
19. SIGNATURE OF CLERK [Illegible]		20. SIGNATURE OF CHIEF OF INSTITUTION [Illegible]		21. SIGNATURE OF ASSISTANT CHIEF [Illegible]	
22. SIGNATURE OF NURSE [Illegible]		23. SIGNATURE OF ATTENDING NURSE [Illegible]		24. SIGNATURE OF CHIEF NURSE [Illegible]	
25. SIGNATURE OF CHIEF OF INSTITUTION [Illegible]		26. SIGNATURE OF ASSISTANT CHIEF [Illegible]		27. SIGNATURE OF NURSE [Illegible]	
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BUREAU V. 2

OV 20 1956

11109

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 99 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAY Middle B. Last MUSSER		4. DATE OF DEATH Month November Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1914
9. AGE (In years last birthday) yrs. 42		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Test Operator		10b. KIND OF BUSINESS OR INDUSTRY Refrigeration	
11. BIRTHPLACE (State or foreign country) York, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lloyd Musser		14. MOTHER'S MAIDEN NAME Marie McKinney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERINEPHRIC ABSCESS, RIGHT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Other cond. cont. 1. Bronchopneumonia, right lung. INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Aneurysm of the middle cerebral artery. 2. Decubitus ulcers of the right and left hip and the sacral area. 3. Thrombosis of the rt. common iliac artery			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) iliac artery	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. VA		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 20, 1956 to November 27, 1956 and that death occurred at 7:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE C. J. Papastrat M.D.		M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 11/28/56	
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-29-56	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town, or county) (State) York, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc.		24a. REC'D BY REGISTRAR DEC 3 1956	
ADDRESS Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto., Md.		24b. REGISTRAR'S SIGNATURE L. J. Lark	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1910		PLACE OF BIRTH Maryland	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Hypertension		FINAL CAUSE Atherosclerosis	
DATE OF DEATH 1956		PLACE OF DEATH Home		OCCUPATION Teacher		EDUCATION High School		RELIGION Roman Catholic		MARITAL STATUS Married	
NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1910		PLACE OF BIRTH Maryland	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Hypertension		FINAL CAUSE Atherosclerosis	
DATE OF DEATH 1956		PLACE OF DEATH Home		OCCUPATION Teacher		EDUCATION High School		RELIGION Roman Catholic		MARITAL STATUS Married	

BUREAU V. S.

DEC 3 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11091

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 E. CHESAPEAKE AVE.		d. STREET ADDRESS 14 E. CHESAPEAKE AVE.	
3. NAME OF DECEASED (Type or print) Augustus REED Naylor, Jr		4. DATE OF DEATH November 3 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY FORD AGENCY REP.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME AUGUSTUS REED NAYLOR		14. MOTHER'S MAIDEN NAME KATIE JEANETTE SUTTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 216-03-8246	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute to Chronic Alcoholism (c), stating the underlying cause lost. DUE TO		INTERVAL BETWEEN ONSET AND DEATH Sudden 7 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/6/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion CEMETERY		22d. LOCATION (City, town, or county) (State) HAMPSTEAD, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John B. ...		24a. REC'D BY REGISTRAR 11/6/56	
ADDRESS TOWSON, MD.		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

STATE OF MARYLAND
DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11111

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u>		d. STREET ADDRESS <u>201 Tuscan Road</u>	
3. NAME OF DECEASED (Type or print) <u>AMY PARKER NEILSON</u> First Middle Last		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH <u>Nov 30</u> 1956	5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Aug 4 1942</u> 9. AGE (In years last birthday) <u>14</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Parker Neilson Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Laura Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Charles W. Frost</u> Address <u>Same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN tumor (Ependymoma)</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>1993 X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 1953, to <u>Nov. 30</u> , 1956, that I last saw the deceased alive on <u>October 25</u> , 1956, and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. G. Speed</u> M.D. <u>11 E. Chan St.</u>		DATE SIGNED <u>11/30/56</u>	
PHYSICIAN'S NAME (Type) <u>William G. Speed, 3rd, M.D. Baltimore, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec 1 1956</u>	<u>Green Mount</u>	<u>Balto, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth J. Jenkins</u> ADDRESS <u>4905 York Road</u>		24a. REC'D BY REGISTRAR DATE <u>4 1956</u>	24b. REGISTRAR'S SIGNATURE <u>T. C. Barry</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11093

11112

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN TB 2mths5dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Lee Last Nelson				4. DATE OF DEATH Month November Day 19 , Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 28, 1886	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN				16. SOCIAL SECURITY NO. 220-22-7631			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 15, 19 56 to Nov. 19, 19 56 that I last saw the deceased alive on Nov. 19, 19 56 , and that death occurred at 9:45a.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar M.D.				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 11-19-56			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Paran Cemetery		22d. LOCATION (City, town, or county) (State) Randalls town, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost 4600 Liberty Heights				24a. REC'D BY REGISTRAR Nov. 20, 1956		24b. REGISTRAR'S SIGNATURE R. E. Harvey	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11094

10975 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND. b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1742 BROOKSVIEW ROAD				d. STREET ADDRESS 1742 BROOKSVIEW ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN L. NODOLNEY				4. DATE OF DEATH Month Day Year NOVEMBER 17, 1956			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 18, 1893	
9. AGE (In years lost birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME VERNON McCLURE				14. MOTHER'S MAIDEN NAME FLORENCE STREBECK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. ?		17. INFORMANT Address MR. JOSEPH A. NODOLNEY SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) HYPERTENSIVE C-V DISEASE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X DIABETES MELLITUS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. , 19 50 , to 11-17 , 19 56 , that I last saw the deceased alive on 11-16 , 19 56 , and that death occurred at 7 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Daniel L. Zalis M.D. 1943 CEDAR LANE BALTO. MD. 11/7/62 PHYSICIAN'S NAME (Type) DANIEL L. ZALIS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/20/56		22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEMETERY		22d. LOCATION (City, town, or county) (State) ELKRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE 13, MARYLAND.				ADDRESS Sandy Sander		24a. REC'D BY REGISTRAR DATE 11-21-56	
				24b. REGISTRAR'S SIGNATURE Wm. M. Kelly, Jr.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11095

Reg. Dist. No.

10976

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTHBROOK</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7833 EASTDALE RD.</u>				d. STREET ADDRESS <u>7833 Eastdale Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Hugh</u> Middle <u>Thomas</u> Last <u>O'Connor</u>				4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 19, 1904.</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NAT. DET. AGENCY</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>THOMAS F. O'CONNOR</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET E. SCHMEISER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.II</u>				16. SOCIAL SECURITY NO. <u>213-074654</u>		17. INFORMANT <u>PEARL O'CONNOR</u> Address <u>SAME.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia - Left</u> 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack E. Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S (Type) <u>Jack E. Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>7801 GERMAN HILL RD., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Gailer</u> ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>				24a. REC'D BY REGISTRAR <u>Nov. 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Tom. Kelly</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NOV 28 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11113 CERTIFICATE OF DEATH

11096

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 14yrs6mth24dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2311 W. North Avenue	
3. NAME OF DECEASED (Type or print) First Jennie Middle Osin Last Osin		4. DATE OF DEATH Month November Day 2 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 78?		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clothing worker	
10b. KIND OF BUSINESS OR INDUSTRY clothing		11. BIRTHPLACE (State or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Abraham Osin	
14. MOTHER'S MAIDEN NAME Fiega Kaplin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Upper respiratory infection DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1953 , to Nov. 2, 1956 , that I last saw the deceased alive on Nov. 2, 1956 , and that death occurred at 11:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 11-2-56			
ACTUAL SIGNATURE Rena Becker		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Rena Becker, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-56	
22c. NAME OF CEMETERY OR CREMATORY Rosedale		22d. LOCATION (city, town, or county) (State) Balto, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewin		ADDRESS 2100 Eutan Pl	
24a. REC'D BY REGISTRAR NOV 7 1956		24b. REGISTRAR'S SIGNATURE V. E. Hurry	

CERTIFICATE OF DEATH

Form No. 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
MARRIAGE		CIVIL STATUS		EDUCATION		OCCUPATION		DATE OF DEATH		PLACE OF DEATH	
MARRIED		MARRIED		HIGH SCHOOL		CIVIL ENGINEER		4/4/68		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF REPORT		PLACE OF REPORT	
HEART DISEASE		NATURAL		4/4/68		MEMPHIS, TENNESSEE		4/4/68		MEMPHIS, TENNESSEE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF SIGNATURE		PLACE OF SIGNATURE	
JAMES EARL RAY		JAMES EARL RAY		4/4/68		MEMPHIS, TENNESSEE		4/4/68		MEMPHIS, TENNESSEE	
TESTIFYING PHYSICIAN		TESTIFYING PHYSICIAN		DATE OF TESTIMONY		PLACE OF TESTIMONY		DATE OF TESTIMONY		PLACE OF TESTIMONY	
JAMES EARL RAY		JAMES EARL RAY		4/4/68		MEMPHIS, TENNESSEE		4/4/68		MEMPHIS, TENNESSEE	

BUREAU V. 3

NOV 2 1968

RECEIVED

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11098

11114

CERTIFICATE OF DEATH

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore 15</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>2007 Ridgewood Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Maude</u> Last <u>Page</u>				4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 - 16 - 1877</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Richard H. Ward</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Fitchett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Carroll C. Ward</u> Address <u>238 Patapsco Avenue Dundalk 22, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Pulmonary embolism</u> <u>154X</u> DUE TO <u>Thrombosis of Right inguinal veins</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic Carcinoma R. inguinal region</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Surgical removal of rectum for Carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ellis S. Margolin</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville Maryland</u> DATE SIGNED <u>11/10/56</u>			
PHYSICIAN'S NAME (Type) <u>ELLIS S. MARGOLIN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street, Balto.</u>				24a. REC'D BY REGISTRAR DATE <u>Nov. 14, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>T. E. Hany</u>	

CERTIFICATE OF DEATH

PLACE OF BIRTH		MARYLAND	
DATE OF BIRTH		JAN 1 1900	
AGE		30 YEARS	
SEX		MALE	
RACE		WHITE	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
MARRIED		YES	
SPOUSE'S NAME		JANE DOE	
DATE OF MARRIAGE		JUN 15 1925	
PLACE OF DEATH		BALTIMORE, MD	
DATE OF DEATH		NOV 15 1956	
TIME OF DEATH		10:00 AM	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. SMITH	
DATE OF SIGNATURE		NOV 15 1956	
SIGNATURE OF REGISTRAR		A. B. JONES	
DATE OF SIGNATURE		NOV 15 1956	

BUREAU V. S.

NOV 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11115
CERTIFICATE OF DEATH

11097

Reg. Dist. No. 45

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. LENGTH OF STAY IN lb 51 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 376 EVERGREEN LANE				d. STREET ADDRESS 376 EVERGREEN LANE			
3. NAME OF DECEASED (Type or print) ADAM PAKASKI (PAKACKI)				4. DATE OF DEATH NOV. 4, 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 20, 1894	
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER OWN FARM		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADAM PAKASKI				14. MOTHER'S MAIDEN NAME MARY MEKOLEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS CATHERINE PAKASKI Address SAME.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Cardio Vascular renal DUE TO (c) 2 yrs						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 15, 1956 to Nov 4, 1956 , that I last saw the deceased alive on Nov 4, 1956 , and that death occurred at 9 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) Baltimore Md DATE SIGNED 11/5/56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 7, 1956		22c. NAME OF CEMETERY OR CREMATORY CHRIST CHURCH CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC ADDRESS BALTIMORE MARYLAND				24a. REC'D BY REGISTRAR NOV 7 1956		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

1956

COUNTY OF BALTIMORE CITY OF BALTIMORE		DEPARTMENT OF HEALTH - BALTIMORE 10	
NAME OF DECEASED JAMES EARL RAY		SEX MALE	
DATE OF BIRTH JANUARY 5, 1928		AGE 28 YEARS	
PLACE OF BIRTH MOBILE, ALABAMA		RACE WHITE	
OCCUPATION MEMBER OF CONGRESS		MARRIAGE SINGLE	
CAUSE OF DEATH SUICIDE BY SHOOTING		PLACE OF DEATH MEMPHIS, TENNESSEE	
DATE OF DEATH APRIL 4, 1968		TIME OF DEATH 2:01 PM	
SIGNATURE OF DECEASED JAMES EARL RAY		SIGNATURE OF WITNESS JAMES EARL RAY	
SIGNATURE OF PHYSICIAN JAMES EARL RAY		SIGNATURE OF CORONER JAMES EARL RAY	
SIGNATURE OF JURY JAMES EARL RAY		SIGNATURE OF JUDGE JAMES EARL RAY	
SIGNATURE OF CLERK JAMES EARL RAY		SIGNATURE OF NOTARY JAMES EARL RAY	

BUREAU V. &

NOV 7 1956

RECEIVED

10987 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
51 TOWN <u>Relay Hill</u>		5 Days		TOWN <u>Baltimore</u>		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Relay Hill Hospital</u>				STREET ADDRESS (If rural give location) <u>3817 S. Hanover St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Mary Elizabeth Peel				Nov. 3 19 56			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	Widowed	Jan. 29, 1880	76 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Retired				—		Frostburg Maryland	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Conrad Lepp				Catherine Krapf			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
No				—		FAMILY 3817 S. HANOVER ST.	

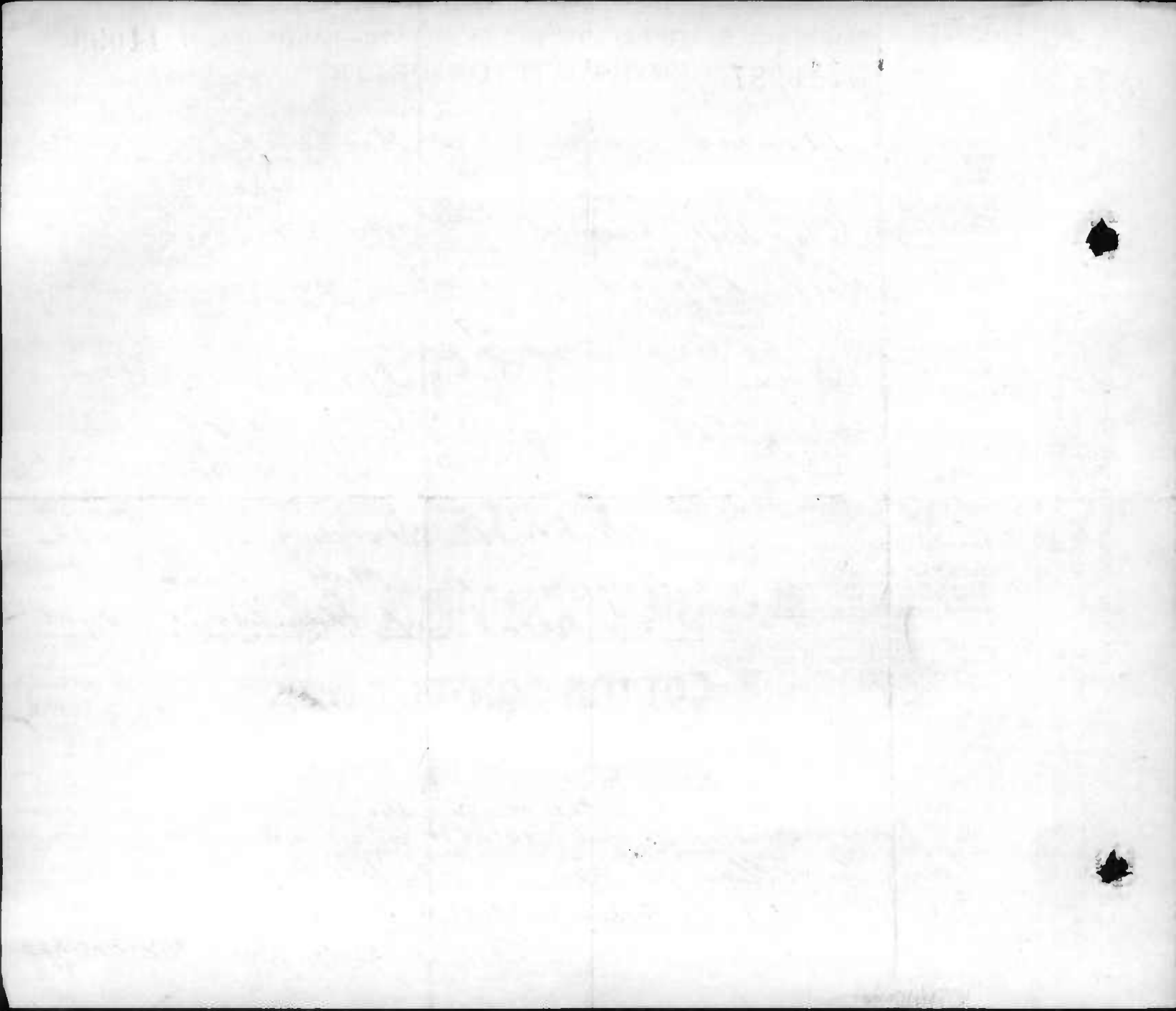
18. MEDICAL CERTIFICATION			Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Mediastinal Bleeding</u>			1 hr
Antecedent causes (s) (b) <u>Metastasis to Mediastinum</u>			?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Carcinoma of the Breast</u>			2 yrs

11. OTHER SIGNIFICANT CONDITIONS				12. AUTOPSY ?			
Conditions contributing to the death but not related to the disease or condition causing death.				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Oct. 29, 1956, to Nov. 3, 1956, that I last saw the deceased alive on Nov. 3, 1956, and that death occurred at 10:55 PM. from the causes and on the date stated above.

SIGNATURE (Degree or title) James C. Hellano, Jr., M.D. ADDRESS Relay Hill Hosp. DATE SIGNED 11/3/56

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	11-7-56	MORELAND MEMORIAL PK.	BALTO	Md.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
11/5/56		McCLINTY FUNERAL HOME 130 E. FORT AVE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11116

CERTIFICATE OF DEATH

11100

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 132 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 119 W. West Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANDREW C. PERKINS		4. DATE OF DEATH Month Day Year November 30 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 15, 1893
9. AGE (In years last birthday) 63		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U? S? A?	
13. FATHER'S NAME John T. Perkins		14. MOTHER'S MAIDEN NAME Mary Bamford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 218-01-3520	
17. INFORMANT Clinical Records, Veterans Administration Hosp.		Address Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CARCINOMA, LEFT TONSIL DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema of lung. Operations 8/8/ & 8/15/56 Removal of tissue from mouth for biopsy.			
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour o. p. m. VA 19		20b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 21, 1956 to November 30, 1956 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Francis G. Dickey M.D. VAH, FORT HOWARD, MARYLAND 11/30/56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, M.D., Chief, Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Isiah L. Brown & Son Funeral Home, 108 W. Montgomery St., Baltimore 30, Md.		24a. REC'D BY REGISTRAR Dec 3, 1956	
24b. REGISTRAR'S SIGNATURE Sawson L. Farkas			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11101

11117 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House In The Pines</u>				STREET ADDRESS (If rural give location) <u>5137 Chesterfield Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Margaret Pieger</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 19 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 20, 1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.V.D. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Pieger</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Weindorfer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Elizabeth Bauer 5137 Chesterfield</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-Cerebral Disease</u>						15 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-13</u> , 19 <u>56</u> , to <u>11-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-19</u> , 19 <u>56</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Wilmer K. Gallagher</u> DATE SIGNED <u>11/20/56</u> ADDRESS (Street, city, town, state) <u>M.D. 209 Frederick Rd., Balt. 28, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>11-23-56</u>		REGISTRAR'S SIGNATURE <u>Victor C. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road.</u>			

CERTIFICATE OF DEATH

Reg. No. 10

1. PLACE OF DEATH

2. DATE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. PLACE OF BIRTH

9. DATE OF BIRTH

10. SEX

11. AGE

12. OCCUPATION

13. CAUSE OF DEATH

14. MANNER OF DEATH

15. PLACE OF BIRTH

BUREAU V. S.

NOV 28 1956

RECEIVED

201164210102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

11102

11118

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caswell Nursing Home</u>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM - THOMAS PITTS</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10 - 1856</u>	9. AGE (In years last birthday) <u>100</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>✓</u>			
17. INFORMANT <u>Geo Bolte Reisterstown Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Heart Failure.</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>November 1955</u> , to <u>November 25 1956</u> , that I last saw the deceased alive on <u>November 25 1956</u> , and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence E. McWilliam</u> M.D.				ADDRESS (Street, city or town, state) <u>Reisterstown Maryland</u>			
DATE SIGNED <u>Nov 25 1956</u>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mr Canuel</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Tipton</u>				ADDRESS <u>Hampsstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>11-26-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary B Elmer</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11119

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11103

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>SMITH</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt 19</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALTVILLE</u> 83X-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BETH. STEEL DISPENSARY</u>				d. STREET ADDRESS <u>RURAL</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT C. POORE POORE</u>				4. DATE OF DEATH Month Day Year <u>11 15 1952</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 29, 1924</u> 32 yrs.	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEELWORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RIVETER</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>ROBT. K. POORE</u>				14. MOTHER'S MAIDEN NAME <u>MABEL HURLEY</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>W W II</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT Address <u>HENDERSON FUNERAL - SALTVILLE VA.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Skull</u> 9023 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell From Height of About 30 FT.</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>11-15 1952</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Steel Plant</u>		20f. (City or town) (County) (State) <u>Sparrows Pt. Balt Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED
EXAMINER'S NAME (Type) <u>JACK C Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				<u>11-15-52</u>
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-17-52</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EMILYBETH CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SALTVILLE VA</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Farley</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>NOV 10 1952</u>		24b. REGISTRAR'S SIGNATURE <u>James L. Farley</u>

RECEIVED

NOV 19 1956

BUREAU V. S.

10977 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLGATE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLGATE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 521 FAIRVIEW AV				d. STREET ADDRESS 521 FAIRVIEW AVE			
3. NAME OF DECEASED (Type or print) First LUCY Middle E. Last POPP				4. DATE OF DEATH Month NOV. Day 14 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 18. 1885	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OWEN W. WISE				14. MOTHER'S MAIDEN NAME ELIZABETH RHODENIZER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Address MRS JAMES LUDWIG 521 FAIRVIEW			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO (c) arterio-sclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 8 , 19 49 , to Nov 14 , 19 56 , that I last saw the deceased alive on Nov 14 , 19 56 , and that death occurred at 5 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Morris A. Jacobs				ADDRESS (Street, city or town, state) 1010 North Point Rd			
PHYSICIAN'S NAME (Type) MORRIS A JACOBS				DATE SIGNED Nov 16 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV 17. 1956		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN		22d. LOCATION (City, town, or county) (State) COLGATE MD	
23. FUNERAL DIRECTOR'S SIGNATURE ULLRICH FUNERAL HOME				ADDRESS 2112 DUNDON		24a. REC'D BY REGISTRAR NOV 16 1956	
				24b. REGISTRAR'S SIGNATURE Wm. Kelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

BUREAU V. S.

NOV 16 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
MAY BE FURNISHED TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11120

CERTIFICATE OF DEATH

Reg. Dist. No.

11105

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>408 S. Rolling Rd.</u>				d. STREET ADDRESS <u>408 S. Rolling Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>K.</u> Last <u>Pressler</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1889</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John W. Kaiserski</u>				14. MOTHER'S MAIDEN NAME <u>Julia Wieber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>9----</u>		17. INFORMANT <u>Wilbur G. Pressler 408 S. Rolling Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Congestive Failure</u> DUE TO (c) <u>Coronary artery disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>3 mos</u> <u>? yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/4</u> , 19 <u>55</u> , to <u>11/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>56</u> , and that death occurred at <u>2nd PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Victor F. Young</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov 30/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Funeral Home - Catonsville Md</u>				24. REC'D BY REGISTRAR DATE <u>DEC 4 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>P. E. Harveys</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11121 CERTIFICATE OF DEATH

11106

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 11 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle B. Last PRICE				4. DATE OF DEATH Month November Day 7, Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-13-93	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN B. PRICE				14. MOTHER'S MAIDEN NAME LAURA BOWERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1				16. SOCIAL SECURITY NO. 218-03-7496		17. INFORMANT VAH, Fort Howard, Md. CLINICAL RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that VA attended the deceased from Oct. 27 , 19 56 , to Nov. 7 , 19 56 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis G. Dickey M.D.				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND			
DATE SIGNED 11/8/56							
PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY M.D., Chief, Medical Service, Fort Howard, Maryland VAH							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF Nov 12 1956		22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY	
22d. LOCATION (City, town, or county) BALTIMORE, MARYLAND				(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home, 4210 Belair Rd., Balto. Md.				ADDRESS		24a. REC'D BY REGISTRAR NOV 14 1956	
24b. REGISTRAR'S SIGNATURE Lawson L. Dickey							

BUREAU V. S.

NOV 14 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. Delay to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11107 41

f. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 22</u>				c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 22</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>106 Arvon Beach Pr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rufus</u> Middle <u>Andrew</u> Last <u>Price</u>				4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/20/04</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker Bethlehem St. Allegheny Co., Va.</u>				11. BIRTHPLACE (State or foreign country) <u> </u>			
13. FATHER'S NAME <u>Chas. H. Price</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Lively</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-8738</u>		17. INFORMANT <u>William A. Price, 1830 W. Lanvale St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack C Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Allegheny Co., Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Lary, 802 Madison Ave.</u>				24a. REC'D BY REGISTRAR <u>Nov 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of medical examiner	
10. Signature of attending physician		11. Signature of coroner		12. Signature of registrar	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of mortician		17. Signature of embalmer		18. Signature of transporter	
19. Signature of interment		20. Signature of burial		21. Signature of cremation	
22. Signature of other		23. Signature of other		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other	
28. Signature of other		29. Signature of other		30. Signature of other	
31. Signature of other		32. Signature of other		33. Signature of other	
34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other	
40. Signature of other		41. Signature of other		42. Signature of other	
43. Signature of other		44. Signature of other		45. Signature of other	
46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other	
52. Signature of other		53. Signature of other		54. Signature of other	
55. Signature of other		56. Signature of other		57. Signature of other	
58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other	
64. Signature of other		65. Signature of other		66. Signature of other	
67. Signature of other		68. Signature of other		69. Signature of other	
70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other	
76. Signature of other		77. Signature of other		78. Signature of other	
79. Signature of other		80. Signature of other		81. Signature of other	
82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other	
88. Signature of other		89. Signature of other		90. Signature of other	
91. Signature of other		92. Signature of other		93. Signature of other	
94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other	
100. Signature of other		101. Signature of other		102. Signature of other	

RECEIVED
NOV 13 1956
BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial cremation, or removal.

VS. A15ME(5)
SM 9/55

11122

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11108

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Penn. b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Love Key				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phila.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pulaski Highway				d. STREET ADDRESS 1744 N. 15th St.					
3. NAME OF DECEASED (Type or print) First Middle Last ANNA (REDD) REDD				4. DATE OF DEATH Month Day Year Nov. 26, 1956					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> separated WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/31/1919			
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser				10b. KIND OF BUSINESS OR INDUSTRY Public		11. BIRTHPLACE (State or foreign country) Rockville, S.C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Jake Crawford				14. MOTHER'S MAIDEN NAME Lula Harris					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 191-16-7048		17. INFORMANT Address Mamie Williams 728 Shirley St., Phila. Penn.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Skull fracture DUE TO (b) Conditions, if any, which gave rise to immediate cause (c) 816x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-truck collision				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour 11:30 p. m. 11/25/1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Balto. Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Nov. 29, 1956	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/30/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE George Ray, Phila., Penn.				ADDRESS		24a. REC'D BY REGISTRAR Dec. 3, 1956			
						24b. REGISTRAR'S SIGNATURE Dr. Walter Hemmety			

STATEMENT OF DEATH - CATHOLIC MEDICAL EXAMINER'S CERTIFICATE OF DEATH

John
John

John V. L. St.

Nov. 26

Nov.

Nov.

(1911)

John

Female

Colored

Married

John

Nov.

Nov.

John V. L. St.

John

John

John Crawford

John

1911-12-20 John Williams 280 Shirley St., John, Tenn.

John

Auto-truck collision

Nov.

Nov.

BUREAU V. S.

DEC 4 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11123

CERTIFICATE OF DEATH

11109

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines-16 Fusting Ave.				d. STREET ADDRESS 8109 Bellona Ave.			
3. NAME OF DECEASED (Type or print) First ELSIE Middle S. Last RIEKER				4. DATE OF DEATH Month Nov. Day 22 Year 19 56			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 28, 1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Wallace Scharf				14. MOTHER'S MAIDEN NAME (unknown) Wesley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Marlin W. Brown - 8109 Bellona Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chs. Hypertensive Cardio-Vascular Disease DUE TO 15 yrs (?) (c)							INTERVAL BETWEEN ONSET AND DEATH 2 ds.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-4 , 19 55 , to 11-22 , 19 56 , that I last saw the deceased alive on 11-21- 19 56 , and that death occurred at 3:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilmer K. Gallagher				ADDRESS (Street, city or town, state) DATE SIGNED 6209 Frederick Road 11/23/56			
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher				Baltimore-28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/56		22c. NAME OF CEMETERY OR CREMATORY Stevensville Cem.		22d. LOCATION (City, town, or county) (State) Stevensville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William J. Vickener & Sons - Baltimore				24a. REC'D BY REGISTRAR DATE 11-27-56		24b. REGISTRAR'S SIGNATURE F. E. Barry	

BUREAU V. S.

NOV 27 1956

RECEIVED

11124 CERTIFICATE OF DEATH

1111030
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A. CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINTHICUM HGTS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 FUSTING AVE</u>		d. STREET ADDRESS <u>408 HAWTHORNE RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET RIORDAN</u>		4. DATE OF DEATH Month Day Year <u>NOV 8 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 16, 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>	9. AGE (In years last birthday) <u>81</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY COLLINS</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JOHN T. RIORDAN JR.</u>		Address <u>5101 OAKLAWN RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Pulmonary edema</u> DUE TO (b) <u>Obstructive C.V. Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 1954, to <u>Nov. 8</u> , 1956, that I last saw the deceased alive on <u>Nov. 6</u> , 1956, and that death occurred at <u>1 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D.C. MacLaughlin</u> M.D.		ADDRESS (Street, city or town state) <u>4508 Edmondson Village</u> DATE SIGNED <u>11/10/56</u>	
PHYSICIAN'S NAME (Type) <u>D.C. MacLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV. 12/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Wipke</u> ADDRESS <u>4101 EDMONDSON</u>		24a. REC'D BY REGISTRAR <u>NOV 14 1956</u>	24b. REGISTRAR'S SIGNATURE <u>F. E. Barry</u>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10979

CERTIFICATE OF DEATH

11111

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22				c. LENGTH OF STAY IN 1b 40 YRS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22				d. STREET ADDRESS 73 WILLOW SPRING RD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 73 WILLOW SPRING RD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EVA MAE RITCHEY				4. DATE OF DEATH Month Day Year NOV. 15 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-23-1878		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN UNRAEPHER				14. MOTHER'S MAIDEN NAME LUCINDA GIBSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WICKROSKY Address DUNDALK, Md. 73 WILLOW SPRING RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X METASTATIC CARCINOMA OF CERVIX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 1/2 YRS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 NOV 1956 to 15 NOV 1956 , that I last saw the deceased alive on 15 NOV 1956 , and that death occurred at 5:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE DR. W. E. BAERMANN				ADDRESS (Street, city or town, state) 33 DUNDALK AVENUE DUNDALK 22, MARYLAND			
PHYSICIAN'S NAME (Type) DR. W. E. BAERMANN				DATE SIGNED 11-15-56			
22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-19-56		22c. NAME OF CEMETERY OR CREMATORY MEADOWBRIDGE		22d. LOCATION (City, town, or county) (State) DUNDALK 22, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Burke Bradley, Dundalk, Md.				24a. REC'D BY REGISTRAR DATE 19 1956		24b. REGISTRAR'S SIGNATURE Wm. Kelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11125

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11112

Reg. Dist. No. 38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 534 Walker Ave. Drumcastle Apts.				d. STREET ADDRESS 534 Walker Ave. Drumcastle Apts.		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) EDNA M. RITTER				4. DATE OF DEATH November 18 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov : 3 : 1900		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Sherwood Oil Company		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME George A. Ritter				14. MOTHER'S MAIDEN NAME Caroline Koch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 216-05-2351		17. INFORMANT Address Howard Ritter 625 Murdock Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion Sudden DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV:21-1956		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. B. Huppert				24a. REC'D BY REGISTRAR 17		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11113

11126 CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4209 Fitch Ave.				d. STREET ADDRESS 4209 Fitch Ave.			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Thomas Middle Rohe Last Rohe				4. DATE OF DEATH Month November Day 20 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Rohe				14. MOTHER'S MAIDEN NAME Ellen Dougherty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-36-8012		17. INFORMANT Address Mrs. Mary M. Rohe 4209 Fitch Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) 6 years							INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Smoking							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12 Nov., 1956 , to 20 Nov., 1956 , that I last saw the deceased alive on 20 Nov., 1956 , and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6801 Belair Rd Balto 6 DATE SIGNED 6-21-56							
ACTUAL SIGNATURE [Signature] M.D. [Signature]							
PHYSICIAN'S NAME (Type) [Signature]							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Fullerton, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lessaahn Funeral Home ADDRESS 7401 Belair Rd				24a. REC'D BY REGISTRAR DATE 11-23-56		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF DEATH	
EDUCATION		RELIGION	
MARRIAGE		PREVIOUS ILLNESS	
DATE OF MARRIAGE		DATE OF PREVIOUS ILLNESS	
NAME OF SURVIVORS		NAME OF PHYSICIAN	
NAME OF FUNERAL HOME		NAME OF BURIAL PLACE	
DATE OF BURIAL		NAME OF MINISTER	
NAME OF CHURCH		NAME OF CEMETERY	
NAME OF INTERVIEWER		NAME OF WITNESS	
NAME OF REGISTRAR		NAME OF CLERK	

BUREAU V. S.

10V 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11127 CERTIFICATE OF DEATH

11114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md. 15-17-2	
c. LENGTH OF STAY IN 1b 1 year		d. STREET ADDRESS 503 Homer Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? NO	
3. NAME OF DECEASED (Type or print) First Frederick Middle A Last Roman		4. DATE OF DEATH Month Nov Day 17 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done in usual line of working life, even if retired) D.C. Unemployment Compensation Bd.		10b. KIND OF BUSINESS OR INDUSTRY Retired since 1952	
11. BIRTHPLACE (State or foreign country) Balto Md.		12. CITIZEN OF WHAT COUNTRY? Montgomery	
13. FATHER'S NAME John A. Roman		14. MOTHER'S MAIDEN NAME Emma Gregory	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-01-9528	
17. INFORMANT Hospital records		Address Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiectasis, Fibrotic pre- monary Interactions, bilateral DUE TO (b) Cardiac fibrillation DUE TO (c) Arrhythmia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arrhythmia		INTERVAL BETWEEN ONSET AND DEATH in 1952 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-12-1955 to 11-17-1956 , that I last saw the deceased alive on Nov 17, 1956 , and that death occurred at 10:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William Newcomer M.D.		DATE SIGNED Nov 20 1956	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Mt. Wilson, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 21, 1956	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Warner L. Humphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR NOV 20 1956		24b. REGISTRAR'S SIGNATURE Dorothy Newell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

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BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11128 CERTIFICATE OF DEATH

11115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. LENGTH OF STAY IN 1b 54			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 505 Dorsey Ave.,				d. STREET ADDRESS 505 Dorsey Ave.,			
3. NAME OF DECEASED (Type or print) Charles A. Sauer Jr.,				4. DATE OF DEATH Nov. 4th, 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21st, 1876	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Charles A. Sauer, Sr.,				14. MOTHER'S MAIDEN NAME Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-03-1634		17. INFORMANT Mrs Bessie Sauer (Wife) Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage. Jackson-type of epilepsy. DUE TO Tumor of the brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arterio sclerosis. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hour 15 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from September, 1955 to 11-4 19 56 , that I last saw the deceased alive on September 12, 1956 , and that death occurred at 11:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 413 Eastern Ave, Essex, Md DATE SIGNED 11-5-1956							
ACTUAL SIGNATURE Eugene C. Baumann		PHYSICIAN'S NAME (Type) Eugene C. Baumann					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 7th, 1956	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Eastern Blvd. Balto, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly		ADDRESS 18 Eastern Blvd Essex		24a. REC'D BY REGISTRAR NOV 7 1956	24b. REGISTRAR'S SIGNATURE Edith Kurland		

BUREAU V. S.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11129 CERTIFICATE OF DEATH

11116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines - 16 Fusting Ave.				d. STREET ADDRESS 3036 Edmondson Ave.			
3. NAME OF DECEASED (Type or print) MARY E. SCHEIB				4. DATE OF DEATH Month Nov. Day 15, Year 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Dept. Edu. Balto.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Harry A. Scheib				14. MOTHER'S MAIDEN NAME Mary L. Sexton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. John L. Scheib - Cedar Rd., Littleton, Mass.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease & Cerebral Vascular Sclerosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 17, 1955 , to Nov. 15, 1956 , that I last saw the deceased alive on Nov. 14, 1956 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry L. Knipp, M.D.				ADDRESS (Street, city or town, state) 4116 Edmondson Ave Baltimore 29 Maryland			
DATE SIGNED 11/16/56							
PHYSICIAN'S NAME (Type) HARRY L. KNIPP M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/56		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto				ADDRESS 17th		24a. REC'D BY REGISTRAR NOV 19 1956	
				24b. REGISTRAR'S SIGNATURE V. E. Harry			

BUREAU V. S.

NOV 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11130 CERTIFICATE OF DEATH

11117

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Court Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles William Schildwachter				4. DATE OF DEATH Month 11 , Day 7 , Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1886	9. Now years (last birthday) 70	10. IF UNDER 1 YEAR Months 7 , Days 12		11. IF UNDER 24 HRS. Hours 12 , Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Schildwachter				14. MOTHER'S MAIDEN NAME Elizabeth Peters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-07-4659		17. INFORMANT Address Howard H. Schildwachter, Pikesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Myocarditis						INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/1/1956 , to 11/7/1956 that I last saw the deceased alive on 11/5/1956 , and that death occurred at 7 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. E. Martin				ADDRESS (Street, city or town, state) Randallstown Md.			
PHYSICIAN'S NAME (Type) Wm. E. MARTIN				DATE SIGNED 11/7/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-1956		22c. NAME OF CEMETERY OR CREMATORY Kriders Cemetery		22d. LOCATION (City, town, or county) (State) Westminster Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell				24a. REC'D BY REGISTRAR Nov 13 1956			
ADDRESS Pikesville, Md.				24b. REGISTRAR'S SIGNATURE Lorothy Newell			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

10988

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11118

Reg. Dist. No.

42

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto Highland</u>	c. LENGTH OF STAY IN 1b <u>5 yr</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto Highland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2806 Helman's ave</u>		d. STREET ADDRESS <u>2806 Helman's ave</u>	
3. NAME OF DECEASED (Type or print) <u>Louis W Schmidt</u> First Middle Last		4. DATE OF DEATH <u>Nov 26</u> Month Day Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 10 1871</u> yrs. <u>85</u>
9. AGE (In years and birthday) <u>85</u> yrs. <u>10</u> Months <u>16</u> Days <u>15</u> Hours <u>56</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Copper Smith</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis W Schmidt</u>		14. MOTHER'S MAIDEN NAME <u>Anna Faltstadt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Elizabeth Schmidt</u> Address <u>2806 Helman's ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular disease</u> (c) <u>General Arteriosclerosis</u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>GEO. S. M. KUEFFER</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KUEFFER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>NW. 26 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 27-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		22d. LOCATION (City, town, or county) (State) <u>Ad Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Walters</u> ADDRESS <u>1414 E. St.</u>		24a. REC'D BY REGISTRAR <u>NOV 27 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Dr. G. M. Kueffer</u>	

BUREAU V. S.

NOV 27 1956

REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11131 CERTIFICATE OF DEATH

11119

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>617 Edmondson Ave</u>				d. STREET ADDRESS <u>617 Edmondson Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gretchen Anna Schwarz</u>				4. DATE OF DEATH Month Day Year <u>Nov. 29, 1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1897</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Gentsch</u>				14. MOTHER'S MAIDEN NAME <u>Anna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Charles F. Schwarz, 617 Edmondson Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL CEREMIA</u> <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMONITIS - DEHYDRATION</u> DUE TO (c) <u>HODGKIN'S DISEASE</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/1</u> , 19 <u>55</u> , to <u>11/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/29</u> , 19 <u>56</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6800 Edmondson Ave</u> DATE SIGNED <u>11/30/56</u> ACTUAL SIGNATURE <u>John H. Shaw</u> M.D. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D. DIST. 28, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation Dec. 4, 1956</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Kasper</u>				ADDRESS <u>4101 Edmondson Ave</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. E. Harvey</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

DEC 3 1955

RECEIVED

11132

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG206 11-13-56 et

CERTIFICATE OF DEATH

11120

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>			
c. LENGTH OF STAY IN <u>Life</u>				d. STREET ADDRESS <u>Box 302 Ridge Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 302 Ridge Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Henry Seifert</u>				4. DATE OF DEATH <u>Nov 5 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 16, 1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Otto Seifert</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Deigert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>August J. Seifert</u>		Address <u>Box 302 Ridge Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular disease</u> DUE TO (c) <u>2 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 5 1956</u> to <u>Nov 5 1956</u> that I last saw the deceased alive on <u>Nov 5 1956</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Baumgardner</u> M.D.				ADDRESS (Street, city or town, state) <u>Balto 6 Md</u>		DATE SIGNED <u>11/5/56</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 8, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Belair Rd. Balto, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>NOV 7 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mr. A. L. Hoffmann</u>			

11133

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
c. LENGTH OF STAY IN 1b 42 DAYS				d. STREET ADDRESS 902 WALNUT AVE ZONE 29			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALBERT SEILER				4. DATE OF DEATH Month NOV Day 29 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 18, 1867		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER		10b. KIND OF BUSINESS OR INDUSTRY BAKERY		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PAUL SEILER				14. MOTHER'S MAIDEN NAME not known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218 22 6507		17. INFORMANT Alma Berkenkemper 902 Walnut Ave. (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from OCT 19, 1956 to NOV 29, 1956 , that I last saw the deceased alive on NOV 29, 1956 , and that death occurred at 7:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler M.D.				DATE SIGNED SPRING GROVE STATE HOSPITAL 11-30-56			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				ADDRESS (Street, city or town, state) Catonville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 3 / 56		22c. NAME OF CEMETERY OR CREMATORY LAUDON PARK		22d. LOCATION (City, town, or county) (State) BAKTO, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. on Type 4101 Edmondson ave				24a. REC'D BY REGISTRAR DEC 3 1956		24b. REGISTRAR'S SIGNATURE P. E. Harry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 3 1956

RECEIVED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) MARTHA SERNOCKY		2. DATE OF DEATH 11/12/56	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) 130 N. Lynnington Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 28	
C. Length of stay in Baltimore 43 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 130 N. Lynnington Ave	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb 2, 1896
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 61
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronaries occlusion (A) DUE TO ANTECEDENT CAUSES Chronic heart failure (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertension arteriosclerosis (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 15, 1956 to Nov. 12, 1956 that I last saw the deceased alive on 11/13, 1956 and that death occurred at 5:30 a.m. from the causes and on the date stated above.			
23A. SIGNATURE Stanley Ankey		23B. ADDRESS 1803 W. Baltimore St.	
23C. DATE SIGNED 11/15/56			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/15/56	24C. NAME OF CEMETERY OR CREMATORY West Holy Redeemer	24D. LOCATION (City, town, or county) (State) Belair Rd Md
DATE RECEIVED BY LOCAL REGISTRAR Nov 15 1956		REGISTRAR'S SIGNATURE Charles W. Schaubert	
FUNERAL DIRECTOR'S SIGNATURE Charles W. Schaubert		ADDRESS 103 McHenry St	

11135 CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phoenix Rd</i>				d. STREET ADDRESS <i>Phoenix Rd</i>			
3. NAME OF DECEASED (Type or print) <i>John William Shaffer</i>				4. DATE OF DEATH <i>November 12 1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 19 1888</i>	
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-20-8644A</i>		17. INFORMANT <i>Mrs Raymond Doris</i> Address <i>Phoenix, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i> <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <i>Oct 56</i> to <i>Nov 56</i> , that I last saw the deceased alive on <i>11 Nov 1956</i> , and that death occurred at <i>2 P M</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Walter T. Kees</i>				ADDRESS (Street, city or town, state) <i>Cockeysville, Md</i> DATE SIGNED <i>12 Nov 56</i>			
PHYSICIAN'S NAME (Type) <i>Walter T. KEES</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-15-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Poplar Grove</i>		22d. LOCATION (City, town, or county) (State) <i>Cockeysville, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Scott Brooks, Sparks, Md</i> ADDRESS _____				24a. REC'D BY REGISTRAR <i>Nov. 16, 56</i>		24b. REGISTRAR'S SIGNATURE <i>M. Elizabeth Groul</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be assigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~pages~~ 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
John Doe		Male		45		1910		Maryland		Baltimore		Maryland		United States	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Teacher		Heart Disease		Natural		1955		Baltimore		Maryland		Maryland		United States	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH	
John Doe		Jane Doe		Teacher		Homemaker		1905		1908		1950		1945	
FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH	
1905		1908		1950		1945		1905		1908		1950		1945	
FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH	
1905		1908		1950		1945		1905		1908		1950		1945	

BUREAU V. 2

NOV 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11135 CERTIFICATE OF DEATH

11124

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>(NMI)</u> Last <u>SHIELDS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/16/91</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>18</u> Days <u>16</u> Hours <u>15</u> Min.	11. IF UNDER 24 HRS. Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM SHIELDS</u>		14. MOTHER'S MAIDEN NAME <u>MARY BANKS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-20-9724</u>	
17. INFORMANT <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF THE RECTUM WITH METASTASES</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>154x</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. p.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 21</u> , 19 <u>56</u> , to <u>November 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>November 24</u> , 19 <u>56</u> , and that death occurred at <u>2:25 A</u> . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Veterans Administration Hospital</u> DATE SIGNED <u>11/25/56</u> ACTUAL SIGNATURE <u>C. J. Papastrat</u> M.D. PHYSICIAN'S NAME (Type) <u>C. J. PAPASTRAT, M.D.</u> <u>Fort Howard, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES R. LAW MORTUARY 802-04 MADISON AVE. BALTO</u>		24a. REC'D BY REGISTRAR <u>11/18/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Lawrence E. Forley</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		WHITE		JAN 5, 1928		MEMPHIS, TENN.	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
APR 4, 1968		11:00 AM		MEMPHIS, TENN.		HEART DISEASE		SUICIDE		[Signature]	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER		16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF OFFICIAL	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

WEEKLY CALIFORNIA

BUREAU V. 2

APR 30, 1968

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11137

CERTIFICATE OF DEATH

11125

Reg. Dist. No.

31

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2115 Holder Ave</u>		d. STREET ADDRESS <u>406 Mt. Holly St.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>Slemaker</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>19 56</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer, Balto. Copper Paint Co.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer, Balto. Copper Paint Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-01-8650</u>	
17. INFORMANT <u>Mrs Janet Jones</u>		Address <u>215 Holder Ave, Woodlawn.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>leukemia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prostatitis & ch. suppuritis</u> DUE TO (c) <u>Arteriosclerosis & hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatectomy Oct 1956</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 1945</u> to <u>Nov 25, 19 56</u> that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>56</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Geo. E. Wells</u> M.D. <u>4100 Edmondson Ave</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witte</u>		ADDRESS <u>4101 Edmondson Ave.</u>	
24a. RECEIVED BY REGISTRAR <u>Nov. 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. Martin</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]	
6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]		10. SIGNATURE OF PHYSICIAN [Faint text]	
11. SIGNATURE OF REGISTRAR [Faint text]		12. SIGNATURE OF WITNESS [Faint text]		13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF WITNESS [Faint text]		15. SIGNATURE OF WITNESS [Faint text]	
16. SIGNATURE OF WITNESS [Faint text]		17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF WITNESS [Faint text]		19. SIGNATURE OF WITNESS [Faint text]		20. SIGNATURE OF WITNESS [Faint text]	
21. SIGNATURE OF WITNESS [Faint text]		22. SIGNATURE OF WITNESS [Faint text]		23. SIGNATURE OF WITNESS [Faint text]		24. SIGNATURE OF WITNESS [Faint text]		25. SIGNATURE OF WITNESS [Faint text]	
26. SIGNATURE OF WITNESS [Faint text]		27. SIGNATURE OF WITNESS [Faint text]		28. SIGNATURE OF WITNESS [Faint text]		29. SIGNATURE OF WITNESS [Faint text]		30. SIGNATURE OF WITNESS [Faint text]	
31. SIGNATURE OF WITNESS [Faint text]		32. SIGNATURE OF WITNESS [Faint text]		33. SIGNATURE OF WITNESS [Faint text]		34. SIGNATURE OF WITNESS [Faint text]		35. SIGNATURE OF WITNESS [Faint text]	
36. SIGNATURE OF WITNESS [Faint text]		37. SIGNATURE OF WITNESS [Faint text]		38. SIGNATURE OF WITNESS [Faint text]		39. SIGNATURE OF WITNESS [Faint text]		40. SIGNATURE OF WITNESS [Faint text]	
41. SIGNATURE OF WITNESS [Faint text]		42. SIGNATURE OF WITNESS [Faint text]		43. SIGNATURE OF WITNESS [Faint text]		44. SIGNATURE OF WITNESS [Faint text]		45. SIGNATURE OF WITNESS [Faint text]	
46. SIGNATURE OF WITNESS [Faint text]		47. SIGNATURE OF WITNESS [Faint text]		48. SIGNATURE OF WITNESS [Faint text]		49. SIGNATURE OF WITNESS [Faint text]		50. SIGNATURE OF WITNESS [Faint text]	
51. SIGNATURE OF WITNESS [Faint text]		52. SIGNATURE OF WITNESS [Faint text]		53. SIGNATURE OF WITNESS [Faint text]		54. SIGNATURE OF WITNESS [Faint text]		55. SIGNATURE OF WITNESS [Faint text]	
56. SIGNATURE OF WITNESS [Faint text]		57. SIGNATURE OF WITNESS [Faint text]		58. SIGNATURE OF WITNESS [Faint text]		59. SIGNATURE OF WITNESS [Faint text]		60. SIGNATURE OF WITNESS [Faint text]	
61. SIGNATURE OF WITNESS [Faint text]		62. SIGNATURE OF WITNESS [Faint text]		63. SIGNATURE OF WITNESS [Faint text]		64. SIGNATURE OF WITNESS [Faint text]		65. SIGNATURE OF WITNESS [Faint text]	
66. SIGNATURE OF WITNESS [Faint text]		67. SIGNATURE OF WITNESS [Faint text]		68. SIGNATURE OF WITNESS [Faint text]		69. SIGNATURE OF WITNESS [Faint text]		70. SIGNATURE OF WITNESS [Faint text]	
71. SIGNATURE OF WITNESS [Faint text]		72. SIGNATURE OF WITNESS [Faint text]		73. SIGNATURE OF WITNESS [Faint text]		74. SIGNATURE OF WITNESS [Faint text]		75. SIGNATURE OF WITNESS [Faint text]	
76. SIGNATURE OF WITNESS [Faint text]		77. SIGNATURE OF WITNESS [Faint text]		78. SIGNATURE OF WITNESS [Faint text]		79. SIGNATURE OF WITNESS [Faint text]		80. SIGNATURE OF WITNESS [Faint text]	
81. SIGNATURE OF WITNESS [Faint text]		82. SIGNATURE OF WITNESS [Faint text]		83. SIGNATURE OF WITNESS [Faint text]		84. SIGNATURE OF WITNESS [Faint text]		85. SIGNATURE OF WITNESS [Faint text]	
86. SIGNATURE OF WITNESS [Faint text]		87. SIGNATURE OF WITNESS [Faint text]		88. SIGNATURE OF WITNESS [Faint text]		89. SIGNATURE OF WITNESS [Faint text]		90. SIGNATURE OF WITNESS [Faint text]	
91. SIGNATURE OF WITNESS [Faint text]		92. SIGNATURE OF WITNESS [Faint text]		93. SIGNATURE OF WITNESS [Faint text]		94. SIGNATURE OF WITNESS [Faint text]		95. SIGNATURE OF WITNESS [Faint text]	
96. SIGNATURE OF WITNESS [Faint text]		97. SIGNATURE OF WITNESS [Faint text]		98. SIGNATURE OF WITNESS [Faint text]		99. SIGNATURE OF WITNESS [Faint text]		100. SIGNATURE OF WITNESS [Faint text]	

BUREAU V. 2

NOV 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11138 CERTIFICATE OF DEATH

11126 38

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>	c. LENGTH OF STAY in 1b <u>2 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3527 Edoppa Rd.</u>		d. STREET ADDRESS <u>3527 Edoppa Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>E</u> Last <u>SMALLWOOD</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 26-1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	11. BIRTHPLACE (State or foreign country) <u>USA</u>
13. FATHER'S NAME <u>Henry Smallwood.</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA McDonald</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>FANNIE R. Smallwood</u> Address <u>3527 E Joppa Rd.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Chronic Myo-Carditis + Endocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pulmonary + Abdominal Involutions</u> (c) <u>General Arterio-Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>year</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>Nov 26</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert M. Foster</u> M.D.		DATE SIGNED <u>Nov 27 1956</u>	
PHYSICIAN'S NAME (Type) <u>2824 ST. Paul</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>11/28/56</u>	<u>Woodlawn Cemetery</u>	<u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F EVANS & Son</u>		ADDRESS <u>8802 HARTFORD RD</u>	24. REC'D BY REGISTRAR <u>DATE 29 1956</u>
		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU A. S.

NOV 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Catonsville Convalescent Home</u>				d. STREET ADDRESS <u>3019 Balder Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>SMELSER</u> Last <u>SMELSER</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31, 1898</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Alexander Slaysman</u>				14. MOTHER'S MAIDEN NAME <u>-- Slaysman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs. Hazel G. Birnie - 25 Gwynn Lake Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis (lullax)</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>96 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>56</u> , to <u>11-2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-2</u> , 19 <u>56</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen Lee Hagness</u> M.D.				ADDRESS (Street, city or town, State) <u>908 Frederick Rd, Catonsville</u>			
DATE SIGNED <u>11-3-56</u>							
PHYSICIAN'S NAME (Type) <u>STEPHEN LEE HAGNESS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amey Lickner & Sons - Balto</u>				ADDRESS <u>17 N. E. St.</u>		24a. RECEIVED BY REGISTRAR <u>11-3-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>F. E. Hargis</u>			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 11128

11140

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Butler</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Falls Rd</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Butler</u> TOWN STREET ADDRESS (If rural give location) <u>Falls Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Margaret</u> (Middle) <u>Ethel</u> (Last) <u>Smith</u>		4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>27</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>17 Sept 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>64</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Talbot Danenport</u>		14. MOTHER'S MAIDEN NAME <u>Elyza Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Daughter - Same address</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 170x IMMEDIATE CAUSE (A) <u>Cancer left breast</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>16 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>19 Nov 56</u> to <u>27 Nov 56</u> , that I last saw the deceased alive on <u>19 Nov 56</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Mary B. Eline</u> ADDRESS <u>Cockeysville Md</u> DATE SIGNED <u>27 Nov 1956</u> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 30/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Gough Methodist</u>		LOCATION (City, town, or county) (State) <u>Baltimore County Md.</u>	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline - Sons Restoration Md</u>	
DATE <u>11-28-56</u>			

MICHIGAN CERTIFICATE OF DEATH

33

1. NAME OF DECEASED

2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH

6. DATE OF DEATH
7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF COUNTY

BUREAU V. S.

1956

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11-25-26 (1) 12/1/26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11129

11141 CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Villa Maria, Notch Cliff</u> <u>Baltimore County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Villa Maria</u>		d. STREET ADDRESS <u>Glenarm Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sister Mary Nativity Spencer</u>		4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Milltown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Schumacher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Sr. Mary Clara Notch Cliff, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Osteo Sarcoma</u> <u>196X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>September</u> , 19 <u>46</u> , to <u>November</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 8</u> , 19 <u>56</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7501 York Rd. Towson, Md.</u> <u>11/10/56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Charles F. O'Donnell</u>		<u>7501 York Rd. Towson, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-12-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NR TOWSON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Gailer</u>		ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>Nov. 13, 1956</u>		<u> </u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form No. 10

1. PLACE OF BIRTH BALTIMORE, MARYLAND		2. DATE OF BIRTH JANUARY 1, 1900	
3. SEX MALE		4. RACE WHITE	
5. OCCUPATION LABORER		6. CAUSE OF DEATH HEART DISEASE	
7. PLACE OF DEATH BALTIMORE, MARYLAND		8. DATE OF DEATH JANUARY 1, 1900	
9. SIGNATURE OF DECEASED [Signature]		10. SIGNATURE OF WITNESS [Signature]	
11. SIGNATURE OF PHYSICIAN [Signature]		12. SIGNATURE OF CLERK [Signature]	
13. SIGNATURE OF JUDGE [Signature]		14. SIGNATURE OF SHERIFF [Signature]	
15. SIGNATURE OF CORONER [Signature]		16. SIGNATURE OF JURY [Signature]	
17. SIGNATURE OF JURY [Signature]		18. SIGNATURE OF JURY [Signature]	
19. SIGNATURE OF JURY [Signature]		20. SIGNATURE OF JURY [Signature]	
21. SIGNATURE OF JURY [Signature]		22. SIGNATURE OF JURY [Signature]	
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99. SIGNATURE OF JURY [Signature]		100. SIGNATURE OF JURY [Signature]	

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NOV 14 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11142 CERTIFICATE OF DEATH

11130 *44*

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2547 Fleet Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARTIN Middle Last STEFANSKI				4. DATE OF DEATH Month November Day 15 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 13, 1896	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY Brewery		11. BIRTHPLACE (State or foreign country) Poland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Thomas Stefanski				14. MOTHER'S MAIDEN NAME Cecelia Wozniak			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Clinical Records, Vet. Adm. Hosp., Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS OF LIVER DUE TO 581.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GASTROINTESTINAL HEMORRHAGE - Duration 4 Weeks							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> attended the deceased from November 9, 1956 , to November 15, 1956 , and that death occurred at 12:25 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 11/16/56 ACTUAL SIGNATURE <i>Walter Pijanowski</i> M.D. WALTER PIJANOWSKI, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-56		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles S. Zeiler Funeral Home, 901 S. Conkling Baltimore, Md.				24a. REC'D BY REGISTRAR DATE NOV 19 1956		24b. REGISTRAR'S SIGNATURE <i>Lawson L. Farley</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 20 1956

BOARD A

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10989 CERTIFICATE OF DEATH

11131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 928 Leeds Avenue		d. STREET ADDRESS 928 Leeds Avenue	
3. NAME OF DECEASED (Type or print) First John Middle William Last Stevens		4. DATE OF DEATH Month November Day 20 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 15, 1886 69 yrs.
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Southern Hotel	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John W. Stevens		14. MOTHER'S MAIDEN NAME Margaret Reiley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-01-4324	
17. INFORMANT Mrs. Henrietta Stevens		Address 928 Leeds Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Arteriosclerotic Coronary Art. Dis. DUE TO (c) Essential Hypertension			INTERVAL BETWEEN ONSET AND DEATH 10 hours 6 yrs ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from April , 19 50 , to Nov 20 , 19 56 that I last saw the deceased alive on Nov 8 , 19 56 , and that death occurred at 7 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl Pass M.D.		ADDRESS (Street, city or town, state) 4001 Wilkens Ave	
PHYSICIAN'S NAME (Type) I. EARL PASS MD		DATE 11-21-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/56	
22c. NAME OF CEMETERY OR CREMATORY Louder Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24. REC'D BY REGISTRAR NOV 20 1956		25. REGISTRAR'S SIGNATURE Dr. H. M. Huffer	

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NOV 26 1956
BUREAU V. 1

11143 CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN IB <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		e. STREET ADDRESS <u>Finlagon</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES MORTON STEWART</u>		4. DATE OF DEATH <u>Nov 13 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Morton Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Lurman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>104-10-10000</u>	
17. INFORMANT <u>Charles Morton Stewart Jr.</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHR. CARDIOVASCULAR DISEASE, ARTERIOSCLEROSIS</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIAC FAILURE (decompensation)</u> DUE TO <u>CEREBRAL VASCULAR ACCIDENT</u> (c) <u>CEREBRAL VASCULAR ACCIDENT</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 10 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 20</u> , 19 <u>56</u> , to <u>Nov. 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 13</u> , 19 <u>56</u> , and that death occurred at <u>3:20</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hugh G. Whitehead</u>		ADDRESS (Street, city or town, state) <u>1201 N. Calvert St. Balt. Md.</u>	
PHYSICIAN'S NAME (Type) <u>Hugh G. Whitehead, M.D.</u>		DATE SIGNED <u>11-14-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Nov. 15 / 56</u>	<u>ST. THOMAS</u>	<u>GREENLAW FOREST</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins</u>		ADDRESS <u>5405 York Rd</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Harold MacRae</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU 1

1956 91 AG

RECEIVED

11144

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>55 Rural; Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lutherville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>01 Eudowood Sanatorium Towson 4, Maryland</u>				STREET ADDRESS <u>17 Seminary Ave.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
		<u>Mary Margaret Stoen</u>		<u>Nov 6 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>7</u>	<u>W</u>	<u>married</u>	<u>Feb 5, 1904</u>	<u>52</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>nurse Rn</u>				<u>Balto Md</u>		<u>U.S.A</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John La Motte</u>				<u>Ida Johnston</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMATION & ADDRESS:			
<u>no</u>		<u>?</u>		<u>Personal History Hospital Records, Eudowood Sanatorium</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>144X</u> Immediate cause (a) <u>Carcinoma of the soft palate with</u>						<u>1948</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>metastasis to glands on both sides of the</u>						<u>84 yrs</u>	
(c) <u>neck and to the base of the palate</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		OF INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		m.					
22. I hereby certify that I attended the deceased from <u>Feb 5, 1956</u> , to <u>Nov 6, 1956</u> that I last saw the deceased alive on <u>Nov 6, 1956</u> , and that death occurred at <u>12 45 PM</u> , from the causes and on the date stated above.							
SIGNATURE (Degree or title)				DATE SIGNED			
<u>Milton B. Kuss</u>				<u>Eudowood Sanatorium - Towson 4, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>11-8-56</u>		<u>Black Rock</u>		<u>Butler, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>11/7/56</u>		<u>Mabel C. Gray</u>		<u>Brooks Funeral Service, Sparks, Md.</u>		<u>J. Scott Brooks</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 13 1956

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11145 CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Highlands</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4208 Baltimore St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E. Stonerifer</u> Last <u>Stonerifer</u>		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>Female</u> COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6. DATE OF BIRTH <u>June 12, 1869</u>	9. AGE (In years last birthday) <u>87</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Dayton, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Dr. Grayson D. Stonerifer</u> Address <u>4208 Balt. St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>UREMIA - CEREBRAL ANGIOSPASM -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR</u> DUE TO <u>DISEASE - PULMONARY EDEMA -</u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/1</u> , 19 <u>55</u> , to <u>11/3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>56</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D. <u>5800 EDWARDS AVE. 7466</u>		DATE SIGNED <u>NOV. 28, 1956</u>	
PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/7/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>	22d. LOCATION (City, town, or county) (State) <u>Potomac Highway Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Shaw</u> ADDRESS <u>501 Baltimore St.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 1956</u>	24b. REGISTRAR'S SIGNATURE <u>John H. Shaw</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2 10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11146

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11135

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto 7</i>		c. LENGTH OF STAY IN 1b <i>10 yrs</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto. 7.</i>		d. STREET ADDRESS <i>7017 Queen Anne Rd.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7017 Queen Anne Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>PHILLIP</i> Middle <i>STROHECKER</i> Last <i>STROHECKER</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>20</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 5, 1889.</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months <i>66</i> Days <i>66</i> Hours <i>66</i> Min. <i>66</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur - Sanitary Dept. City Sanitation</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Balto.</i>	
11. BIRTHPLACE (State or foreign country) <i>W.D.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>W.D.A.</i>	
13. FATHER'S NAME <i>John Strohecker</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Scholte</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no.</i>		16. SOCIAL SECURITY NO. <i>no.</i>	
17. INFORMANT <i>Anna Strohecker (husband)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>no.</i> DUE TO (c) <i>no.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive C.-V. & disease.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>no.</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>none</i> p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none.</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>D. D. Caples,</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>11-20-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/24/1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		24a. REC'D BY REGISTRAR <i>Dr. M. Martin</i>	
ADDRESS <i>Ellsworth Armacost - 4600 Liberty Hgts. Ave</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. M. Martin</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED
NOV 28 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11147

CERTIFICATE OF DEATH

11136

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 28 Days				d. STREET ADDRESS 505 Cumberland Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle A Last STUBBS				4. DATE OF DEATH Month November Day 1 Year 1956			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/22/86	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Drug Store	
11. BIRTHPLACE (State or foreign country) Hoopersville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Stubbs		14. MOTHER'S MAIDEN NAME Willie Travers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. 217 01 9850		17. INFORMANT Address Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177x CARCINOMA OF THE PROSTATE WITH GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from October 4, 1956 , to November 1, 1956 , and that death occurred at 12:15AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) VAH, Fort Howard, Md.				DATE SIGNED 11/2/56			
ACTUAL SIGNATURE C. J. Papastrat M.D.				PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles R. Law Mortuary, 802-04 Madison Ave., Baltimore 1, Md.				24a. REC'D BY REGISTRAR DATE NOV 7 1956		24b. REGISTRAR'S SIGNATURE Rawson L. Harkey	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		35		1920		Maryland		Baltimore		Heart Disease		November 1, 1956		10:00 AM		Home		Dr. J. Smith		J. Doe	

RECEIVED
NOV. 2 1956
BUREAU V. 8

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G208 12-10-56 et

11145 CERTIFICATE OF DEATH

11137 38

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ruxton</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ruxton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7621 Bellona Avenue</i>		d. STREET ADDRESS <i>7621 Bellona Avenue</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Roberta Sullivan</i>		4. DATE OF DEATH Month Day Year <i>November 27th 19 56</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 21, 1886</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Garrett Sullivan</i>		14. MOTHER'S MAIDEN NAME <i>Mary Akehurst</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Paul T. Parrish</i>		Address <i>7621 Bellona Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Sclerosis</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerosis</i> DUE TO (c) <i>Chronic Myocarditis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1951</i> <i>1951</i> <i>1948</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>May 22, 1951</i> to <i>Nov. 27, 1956</i> that I last saw the deceased alive on <i>Nov. 27, 1956</i> , and that death occurred at <i>11:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul Brown</i>		ADDRESS (Street, city or town, state) <i>3602 Liberty Hgts. ave. Balt - 15 Md.</i>	
DATE SIGNED <i>11/28/56</i>			
PHYSICIAN'S NAME (Type) <i>Paul Brown M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/1/1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Stone Chapel Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>DEC 3 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10980 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1762 Brookview Rd</u>		STREET ADDRESS (If rural, give location) <u>1762 Brookview Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Anthony</u> (Middle) <u>M.</u> (Last) <u>Swiderski</u>		4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>2</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan 14 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>New York Buffalo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Swiderski</u>		14. MOTHER'S MAIDEN NAME <u>Mary Janka</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>214-01-7782</u>	
17. INFORMANT AND ADDRESS <u>Anthony T. Swiderski 1762 Brookview Rd</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>4 Mo</u>
157X Immediate cause (a) <u>Carcinoma of the Pancreas</u>			
Antecedent cause(s) (b) _____			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov 2, 1956, to Nov 2, 1956, that I last saw the deceased alive on Nov 2, 1956, and that death occurred at 2:45 P. m., from the causes and on the date stated above.

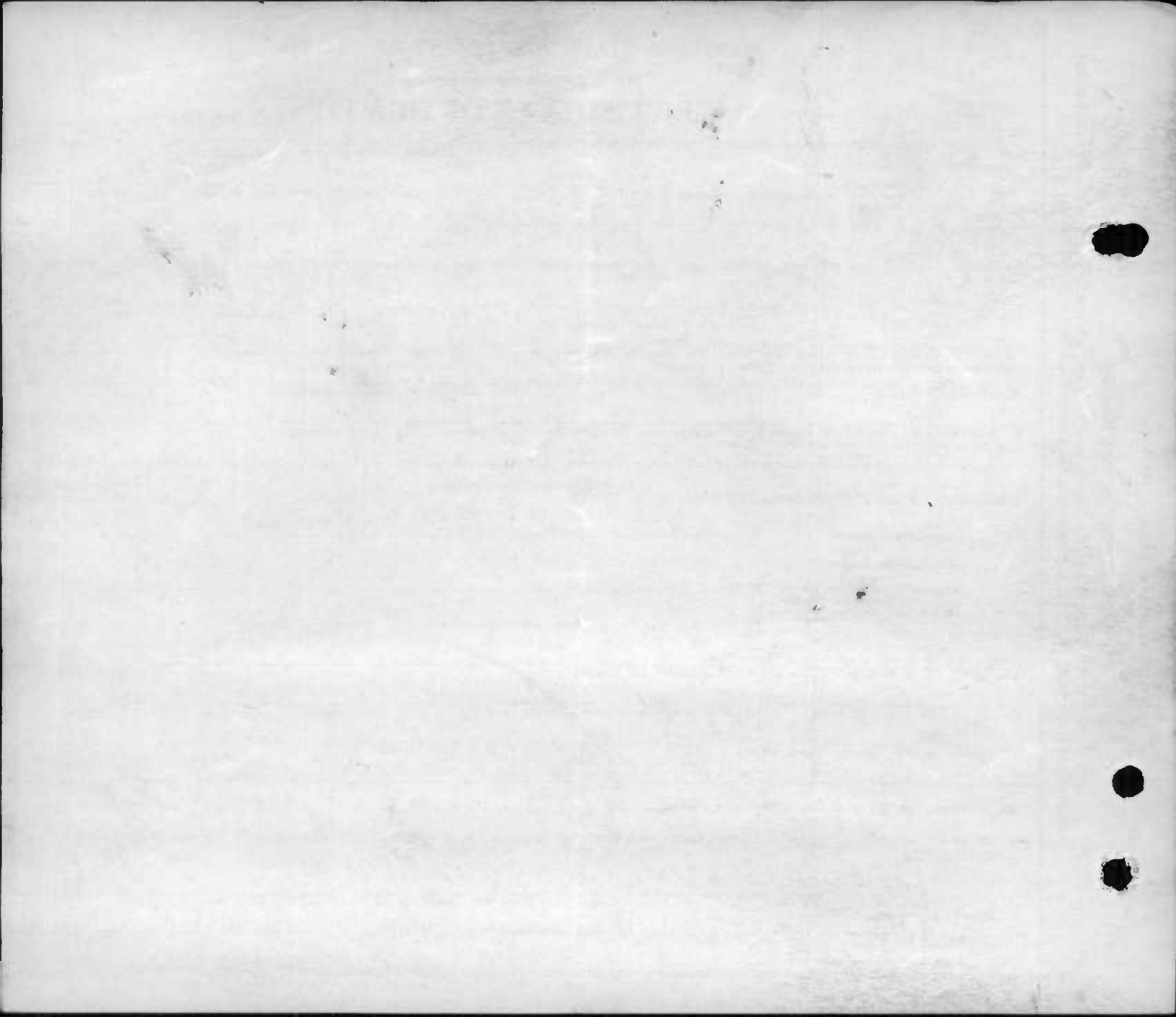
SIGNATURE J. Lefter C. Mockovich M.D. ADDRESS 6714 Holahid Ave DATE SIGNED 11-2-56

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Nov 5-56</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>	LOCATION (City, town, or county) (State) <u>German Hill Rd. Balto. Co. Md</u>
DATE REC'D BY LOCAL REG. <u>November 3, 1956</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>W. J. Pappalardo 1800 E. Lombard St</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11149 CERTIFICATE OF DEATH

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home				d. STREET ADDRESS 821 S. Warwick Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Jennie D. Middle Tarring Last				4. DATE OF DEATH Month Nov. Day 1 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1869	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New London, Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Otis Dimock				14. MOTHER'S MAIDEN NAME Harriet D. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 131-10-1452D		17. INFORMANT Address Ola Tarring Inciardi 821 S. Warwick Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 days ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 48 , to Nov 1 , 19 56 , that I last saw the deceased alive on 11/1 , 19 56 , and that death occurred at 6:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel P. Pless M.D.				ADDRESS (Street, city or town, state) 3326 Funderburg St			
DATE SIGNED Nov 5, 1956				DATE SIGNED T. E. Harvey			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/56		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Avenue		24a. RECEIVED BY REGISTRAR Nov 5, 1956	
						24b. REGISTRAR'S SIGNATURE T. E. Harvey	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 5 AC.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 TOWSON				c. LENGTH OF STAY IN 1b 77 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 410 VIRGINIA AVE.				d. STREET ADDRESS 410 VIRGINIA AVE			
3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last THOMAS				4. DATE OF DEATH Month NOV. Day 10 Year 1956			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/4/79		9. AGE (In years lost birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ?		17. INFORMANT FANNY THOMAS		Address 410 VIRGINIA AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from AUG. _____, 19 56 , to NOV. 10 _____, 19 56 , that I last saw the deceased alive on NOV. 10 _____, 19 56 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE William G. Pillsbury M.D. _____ TIMONUM, MD 11/10/56 PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/14/56		22c. NAME OF CEMETERY OR CREMATORY Pleasant Rest		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Chatham 1701 McCallum St Balto. Md.				24a. REC'D BY REGISTRAR DATE NOV 14 1956		24b. REGISTRAR'S SIGNATURE Robert G. Gynn	

RECEIVED

NOV 14 1956

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE
CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. TIME OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]
12. DATE OF REGISTRATION: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11141
11151 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

25

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton (rural)		c. LENGTH OF STAY IN life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton (rural)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Big Falls Rd.				d. STREET ADDRESS Big Falls Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leonard Lee Middle THOMAS Last				4. DATE OF DEATH Nov. 3 Month Nov. Day 3 Year 1956					
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-19-56		9. AGE (In years last birthday) 2 yrs. 15 mos. 15 days	IF UNDER 1 YEAR Months 2 Days 15	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) York, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jack Hobert Thomas				14. MOTHER'S MAIDEN NAME Loretta Ridley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hobert Thomas, Monkton, Md. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH other		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-4-56		22c. NAME OF CEMETERY OR CREMATORY Jessops Methodist		22d. LOCATION (City, town, or county) (State) Sparks, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks ADDRESS Sparks, Md.				24a. REC'D BY REGISTRAR NOV 5 1956 DATE		24b. REGISTRAR'S SIGNATURE Chestnut L. Lutter		DATE SIGNED 11/3/56	

MAXIMUM STATE OF HEALTH - BATHING IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y. 4

NOV 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND-STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
Baltimore City Health Department
CERTIFICATE OF DEATH

11152

11142

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6212 Frankford Avenue</i>				d. STREET ADDRESS <i>6212 Frankford Avenue</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Mr. Robert</i> Middle <i>Tilford</i> Last <i>Tilford</i>				4. DATE OF DEATH Month <i>November</i> Day <i>16</i> Year <i>1956</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 13, 1889</i>	
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>10</i> Hours <i>15</i> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel Worker</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>John Tilford</i>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-07-4576</i>		17. INFORMANT Address <i>Mrs. Grace B. Tilford, 6212 Frankford</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tumor of the Brain</i> <i>237x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>None</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct. 15, 1956</i> to <i>Nov 16</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Nov 12</i> , 19 <i>56</i> , and that death occurred at <i>5:30 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6210 York Road, Baltimore, 12, "a.</i> DATE SIGNED ACTUAL SIGNATURE <i>A.S. Chalfant</i> M.D. PHYSICIAN'S NAME (Type) <i>A. S. Chalfant</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/20/1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lutheran Church Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Enola, Pennsylvania</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>				24a. REC'D BY REGISTRAR DATE <i>Nov. 20, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. L. M. Bacon</i>	

MEDICAL CERTIFICATION

BUREAU V. 3

NOV 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11153 CERTIFICATE OF DEATH

11143 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>6 wks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armecost Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u> d. STREET ADDRESS <u>4404 Rokeby Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Caroline</u> Middle <u>A.</u> Last <u>Tillery</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>19 56</u>				
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18, 1887</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 74 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>			
13. FATHER'S NAME <u>Theodore Loose</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Mrs Paul L. Falkemer</u> Address <u>4404 Rokeby Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Rheumatic & arteriosclerotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic & U. S. disease</u> DUE TO (c) <u>Coronary Sclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>June 1955</u> to <u>Nov 13, 1956</u> , that I last saw the deceased alive on <u>Nov 13, 1956</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>3033 W Kox Rd</u>			DATE SIGNED _____				
PHYSICIAN'S NAME (Type) <u>M. Paul Byerly</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
22d. LOCATION (City, town, or county) <u>A.A. Co. Md.</u>		(State) _____					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>			ADDRESS <u>4101 Edmondson Ave</u> DATE <u>NOV 20 1956</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

TO BE FILLED BY DEATH REGISTRAR NAME OF DECEASED SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION CAUSE OF DEATH MANNER OF DEATH TIME OF DEATH PLACE OF DEATH SIGNATURE OF REGISTRAR DATE		TO BE FILLED BY PHYSICIAN NAME OF PHYSICIAN ADDRESS CITY STATE ZIP SIGNATURE OF PHYSICIAN DATE	
TO BE FILLED BY CORONER NAME OF CORONER ADDRESS CITY STATE ZIP SIGNATURE OF CORONER DATE		TO BE FILLED BY FUNERAL HOME NAME OF FUNERAL HOME ADDRESS CITY STATE ZIP SIGNATURE OF FUNERAL HOME DATE	
TO BE FILLED BY BURIAL PLACE NAME OF BURIAL PLACE ADDRESS CITY STATE ZIP SIGNATURE OF BURIAL PLACE DATE		TO BE FILLED BY OTHER NAME OF OTHER ADDRESS CITY STATE ZIP SIGNATURE OF OTHER DATE	

40 V. 2

NOV 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11154 CERTIFICATE OF DEATH

11144

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u>		c. LENGTH OF STAY IN 1b <u>37 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>T.</u> Last <u>TRICE</u>		4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/23/94</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>62</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>	
11. BIRTHPLACE (State or foreign country) <u>Seaford, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Trice</u>		14. MOTHER'S MAIDEN NAME <u>Rosie Williamson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 26</u> , 19 <u>56</u> , to <u>November 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 3, 1956</u> , and that death occurred at <u>5:00 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, Fort. Howard, Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>C. J. Papastradt M.D.</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>C. J. PAPASTRADT, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 6, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Windy Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Trappe, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Frampton Carroll</u>		24a. REC'D BY REGISTRAR <u>NOV 7 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Douglas L. Farley</u>			

BUREAU V. S.

1956 2 NOV

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11145

11155

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY YORK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
					Stewartstown RD #3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Delaney Valley Road				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First R. Middle EUGENE Last TROUT				4. DATE OF DEATH Month November Day 27 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/35		9. AGE (in years last birthday) 20 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Hauling		11. BIRTHPLACE (State or foreign country) East Hopewell Township, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reed S. Trout				14. MOTHER'S MAIDEN NAME Pauline Crull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 204-28-3722		17. INFORMANT Reed Trout Stewartstown Pa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury of head 819X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Sideswiped bridge and crashed into span					
20c. TIME OF INJURY Month, Day, Year Hour 11:30 o. m. 11/27 1956	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Baltimore, Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. S. Fisher				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-56		22c. NAME OF CEMETERY OR CREMATORY Stewartstown		22d. LOCATION (City, town, or county) (State) Stewartstown York Co. Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Orshum				ADDRESS Stewartstown Pa.		24a. REC'D BY REGISTRAR 11/29/56	
				24b. REGISTRAR'S SIGNATURE Charles J. Fenton			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 3 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

11156

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u>		c. LENGTH OF STAY IN 1b <u>ESSEX</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>38 CRAFTON RD.</u>		d. STREET ADDRESS <u>38 CRAFTON RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>ULRICH</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 16. 1874</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MARGARET MENINGER</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>fever</u>			INTERVAL BETWEEN ONSET AND DEATH <u>fever</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>Nov 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>56</u> , and that death occurred at <u>10:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert J. Lyden</u>		ADDRESS (Street, city or town, state) <u>815 Eastern Ave, Balt. 21, Md</u>	
PHYSICIAN'S NAME (Type) <u>R. J. LYDEN</u>		DATE SIGNED <u>Nov 2 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV. 5-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT CARMEL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		ADDRESS <u>Essex 212d. N</u>	
24a. REC'D BY REGISTRAR <u>Edith Hurley</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		Male		45		1910		Maryland		Farmer		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
1956		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
17. FULL NAME OF PHYSICIAN		18. FULL NAME OF REGISTRAR		19. FULL NAME OF WITNESSES		20. FULL NAME OF DECEASED		21. FULL NAME OF DECEASED		22. FULL NAME OF DECEASED		23. FULL NAME OF DECEASED		24. FULL NAME OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 1

NOV 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11147

11157 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER (20)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at Home</u>				d. STREET ADDRESS <u>1212 4th Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>KARL</u> Middle <u>A.</u> Last <u>VAN BIBBER</u>				4. DATE OF DEATH Month <u>11</u> - Day <u>19</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13 - 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Met. Ins.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Beth-Steel</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>CLAUDE VAN BIBBER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-07-4715</u>		17. INFORMANT <u>CEIL VAN BIBBER</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> <u>411X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Rheumatoid Cardio-vascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u> <u>30 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Nov 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 19</u> , 19 <u>56</u> , and that death occurred at <u>6:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis Semenov</u>				ADDRESS (Street, city or town, state) <u>1437 Fendoga Ave</u>		DATE SIGNED <u>11/21/56</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>				<u>Baltimore 20, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Connelly - Exec. Md.</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>11-23-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

BUREAU V. S.

1956 NOV 28

RECEIVED

CERTIFICATE OF DEATH

11148

Reg. Dist. No.

30

11158

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 2 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hortense Middle NMI Last Ward				4. DATE OF DEATH Month Nov. Day 24 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 29, 1876		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Charles Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Coelistius Hayden			
14. MOTHER'S MAIDEN NAME Eliza Bailey				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service) ?			
16. SOCIAL SECURITY NO. ?				17. INFORMANT Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-43x Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Cerebral hemorrhage Hypertensive cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 3 days 4 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 12, 1956 - Nov. 24, 1956 , 19____, that I last saw the deceased alive on Nov. 24, 1956 , 19____, and that death occurred at 2:45 P. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles Ward M.D.				PHYSICIAN'S NAME (Type) Dr. Charles Ward Spring Grove State Hosp. Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/25/56		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Washington Laurel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc. 317 P St Ave S.E. Wash. D.C.				24a. REC'D BY REGISTRAR WASH. 3 NOV 27 1956		24b. REGISTRAR'S SIGNATURE F. E. Harry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES J. JONES		35		M		W		11-15-1956	
PLACE OF DEATH		CITY		COUNTY		STATE		COUNTRY	
BOSTON		BOSTON		SUFFOLK		MASSACHUSETTS		UNITED STATES	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF BIRTH	
LABORER		HEART DISEASE		NATURAL		3 WEEKS		11-1-1956	
PREVIOUS ILLNESS		DATE OF EXAMINATION		DATE OF INTERVIEW		DATE OF SIGNATURE		DATE OF FILING	
NONE		11-15-1956		11-15-1956		11-15-1956		11-15-1956	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

NOV 24 1956

RECEIVED

11159 CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1913 Oak Drive		d. STREET ADDRESS 1913 Oak Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Francis John Warns		4. DATE OF DEATH Month Day Year Nov. 9 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1907
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Contractor		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Warns		14. MOTHER'S MAIDEN NAME Margaret Hohman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-28-7328	
17. INFORMANT Eileen E. Warns		Address 1913 Oak Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion (c) Hypertension with Cardio Vascular Disease 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-9 , 19 56 , to 10-9 , 19 56 , that I last saw the deceased alive on 10-9 , 19 56 , and that death occurred at 2 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas G. Abbott		M.D. Dr. Thomas G. Abbott DATE SIGNED 11-11-56	
PHYSICIAN'S NAME (Type) Thomas G. Abbott		4509 Liberty Heights Ave	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-12-1956	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE E. Howard Strong		ADDRESS 307 W North Ave.	
24a. REC'D BY REGISTRAR DATE 11-13-56		24b. REGISTRAR'S SIGNATURE Dr. Jm. E. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11151

11160 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY in 1b 12 days		d. STREET ADDRESS 1319 West 37th Street - Balto.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Anna Last Webster		4. DATE OF DEATH Month November Day 26 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 16 1909
9. AGE (In years last birthday) 67 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Martin Jonas		14. MOTHER'S MAIDEN NAME Victoria	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Johnston		Address 1437 Reynolds St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 14, 19 56 , to Nov. 26, 19 56 , that I last saw the deceased alive on Nov. 26, 19 56 , and that death occurred at 6:45 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		DATE SIGNED 11-26-56	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11/28/56	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery Balto. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. ...		24a. REC'D BY REGISTRAR Nov. 29 1956	
24b. REGISTRAR'S SIGNATURE F. E. Hany			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		DATE OF BIRTH	
OCCUPATION		SEX	
MARITAL STATUS		RACE	
EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		TIME OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
CITY		CITY	
COUNTY		COUNTY	
STATE		STATE	

BUREAU V. 8

NOV 29 1956

RECEIVED

Handwritten notes and signatures at the bottom of the form, including dates like 11/29/56 and names like F. M. ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11161 CERTIFICATE OF DEATH

11150 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 110 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 1511 NORTHERN PARKWAY							
3. NAME OF DECEASED (Type or print) First EDWARD Middle (NMI) Last WESTER				4. DATE OF DEATH Month NOVEMBER Day 22, Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 2, 1896	
9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent				10b. KIND OF BUSINESS OR INDUSTRY Electronic Business Newark, New Jersey			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William Wester				14. MOTHER'S MAIDEN NAME Katherine Kiel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW I				16. SOCIAL SECURITY NO. 136-05-0778			
17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE WITH GENERALIZED METASTASES 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 2 YEARS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 4, 1956 , to November 22, 1956 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. J. Papastrat MD. M.D. VAH, FORT HOWARD, MARYLAND 11/23/56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-26-56			
22c. NAME OF CEMETERY OR CREMATORY Baltimore National				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				24a. REC'D BY REGISTRAR DATE 3 1956			
ADDRESS 6009 Harford Rd., Balto., Md.				24b. REGISTRAR'S SIGNATURE Dawson L. Farber			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. HENRY		2. SEX MALE		3. AGE 45		4. RACE WHITE		5. BIRTH DATE JAN 15 1900		6. BIRTH PLACE BALTIMORE, MARYLAND	
7. DECEASED DATE DEC 3 1956		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE BALTIMORE, MARYLAND		10. DECEASED CAUSE HEART DISEASE		11. DECEASED DOCTOR J. H. HENRY		12. DECEASED HOSPITAL BALTIMORE HOSPITAL	
13. DECEASED ADDRESS 1234 BALTIMORE ST. BALTIMORE, MARYLAND		14. DECEASED OCCUPATION CLERK		15. DECEASED MARITAL STATUS MARRIED		16. DECEASED EDUCATION HIGH SCHOOL		17. DECEASED RELIGION METHODIST		18. DECEASED SERVICE ARMY	
19. DECEASED SIGNATURE J. H. HENRY		20. DECEASED ADDRESS 1234 BALTIMORE ST. BALTIMORE, MARYLAND		21. DECEASED OCCUPATION CLERK		22. DECEASED MARITAL STATUS MARRIED		23. DECEASED EDUCATION HIGH SCHOOL		24. DECEASED RELIGION METHODIST	
25. DECEASED SIGNATURE J. H. HENRY		26. DECEASED ADDRESS 1234 BALTIMORE ST. BALTIMORE, MARYLAND		27. DECEASED OCCUPATION CLERK		28. DECEASED MARITAL STATUS MARRIED		29. DECEASED EDUCATION HIGH SCHOOL		30. DECEASED RELIGION METHODIST	

BUREAU V. S.

DEC 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG208 12-12-56 et

CERTIFICATE OF DEATH

11152

Reg. Dist. No.

30

11162

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 4 months		d. STREET ADDRESS 3834 Elmley Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home-329 Harlem Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUGUSTA Middle ELIZABETH Last WHITE		4. DATE OF DEATH Month Nov. Day 28 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Approx. 76 yrs.
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Eldridge Windsor	
14. MOTHER'S MAIDEN NAME Mary Webster		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. E. Gerald White - 3834 Elmley Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema right 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary embolism DUE TO (c) Myocarditis chronic		INTERVAL BETWEEN ONSET AND DEATH I day I day 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial hypertrophy. 5 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no injury		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> no injury	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) no injury		20f. (City or town) (County) (State) no injury	
21. I certify that I attended the deceased from Dec 6th 1955 , to Nov 28 1956 , that I last saw the deceased alive on November 28, 1956 , and that death occurred at 4.30 P.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 516 Cathedral Street, Balto Md		DATE SIGNED James G. Marston	
ACTUAL SIGNATURE James G. Marston		M.D. 516 Cathedral Street Balto I Md	
PHYSICIAN'S NAME (Type) James Graham Marston, M.D.		ADDRESS 516 Cathedral Street Balto I Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/56	
22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto		ADDRESS 17th	
24a. REC'D BY REGISTRAR DEC 3 1956		24b. REGISTRAR'S SIGNATURE P. E. Lany	

BUREAU V. S.

DEC 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11153 28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson (Rodgers Forge)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 220 Hopkins Road				d. STREET ADDRESS 220 Hopkins Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VIOLET Middle (Frances) Last WHITE				4. DATE OF DEATH Month November Day 19 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 19, 1898		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wm. M. Jones				14. MOTHER'S MAIDEN NAME Laura B. -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Marion Roettger - 1352 Winston Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Towson Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 11/19/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/21/56		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor & Sons - Balto 17 Md				24a. RECEIVED BY REGISTRAR DATE Nov. 20, 1956			
				24b. REGISTRAR'S SIGNATURE Malcolm Gray			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Maryland

Albino

Tolson (L. B. Nichols)

220 Hopkins Road

220 Hopkins Road

October 19, 1956

WHITE

VIOLIST

Female

White

28

1956

Home

1956

Home

Home

BUREAU V. S.

NOV 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11154

11164 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland				c. LENGTH OF STAY IN 1b 74 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month November Day 3 Year 1956				5. STREET ADDRESS 2734 W. Lafayette Street			
3. NAME OF DECEASED (Type or print) First MELVIN Middle R. Last WILLIAMS		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/23/20	
5. SEX Male		9. AGE (In years last birthday) 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		11. BIRTHPLACE (State or foreign country) Boring, Md.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Boring, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Williams				14. MOTHER'S MAIDEN NAME Margaret E. Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes		16. SOCIAL SECURITY NO. 219-12-7842		17. INFORMANT Address Clin. Rec. Folder, Vet. Adm. Hosp., Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO PNEUMONITIS DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF STOMACH DUE TO (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 21, 1956 , to November 3, 1956 and that death occurred at 7:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MD. DATE SIGNED ACTUAL SIGNATURE Walter H. Levy M.D. PHYSICIAN'S NAME (Type) WALTER H. LEVY, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7, 1956		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Katie Williams				24a. REC'D BY REGISTRAR Nov 7 1956		24b. REGISTRAR'S SIGNATURE James L. Harvey	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. COLOR</p>		<p>9. RELIGION</p>		<p>10. EDUCATION</p>	
<p>11. CAUSE OF DEATH</p>		<p>12. MANNER OF DEATH</p>		<p>13. PLACE OF DEATH</p>		<p>14. DATE OF DEATH</p>		<p>15. TIME OF DEATH</p>	
<p>16. SIGNATURE OF PHYSICIAN</p>		<p>17. SIGNATURE OF REGISTRAR</p>		<p>18. SIGNATURE OF WITNESS</p>		<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF NEXT OF KIN</p>	

BUREAU V. 8

NOV 7 1966

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 FilmG207 11-19-56 et

CERTIFICATE OF DEATH

Item 2 FilmG207 11-20-56 et

11155
20

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. LENGTH OF STAY IN 1b Lif.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry Winter		4. DATE OF DEATH Nov. 4, 1956	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1873
9a. AGE (In years lost birthday) 82 yrs.		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith, Crown Cork & Seal Co.		10b. KIND OF BUSINESS OR INDUSTRY Balto. Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Winter		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-03-94864	
17. INFORMANT Mrs Naomi F. McQuaid		Address 322 Allendale St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 141X Carcinoma tongue with cerebral metastasis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 9 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-8 , 1955, to Nov. 4 , 1956, that I last saw the deceased alive on 11-4 , 1956, and that death occurred at 11:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Schaefer M.D.		ADDRESS (Street, city or town, state) 401 Random Road Balto. 29 Md.	
DATE SIGNED Nov. 7, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7/56	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Wipke		ADDRESS 4101 Edmondson Ave.	
24a. REC'D BY REGISTRAR NOV 13 1956		24b. REGISTRAR'S SIGNATURE F. E. Hays	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1921	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White	
9. PLACE OF DEATH Baltimore, Maryland		10. CAUSE OF DEATH Suicide		11. MANNER OF DEATH Homicide		12. DATE OF DEATH April 4, 1968	
13. TIME OF DEATH 11:00 AM		14. PLACE OF INTERMENT None		15. NAME OF FUNERAL HOME None		16. SIGNATURE OF DECEASED None	
17. SIGNATURE OF WITNESS None		18. SIGNATURE OF PHYSICIAN None		19. SIGNATURE OF CORONER None		20. SIGNATURE OF JUDGE None	

BUREAU V. S.

NOV 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG207 11-26-56 et

11156

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY 1200	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 233 Pinewood Road		d. STREET ADDRESS 233 Pinewood Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ottile Middle P. Last Winters		4. DATE OF DEATH Month 11 Day 16 Year 1956	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1874
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 11 Days 16 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Siebert		14. MOTHER'S MAIDEN NAME Henrietta Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Carl Sipes, 233 Pinewood Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vas. Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 53 , to 16 Nov , 19 56 , that I last saw the deceased alive on 15 Nov , 19 56 , and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dundalk Md DATE SIGNED 22 Nov			
ACTUAL SIGNATURE W. H. Morrison M.D.			
PHYSICIAN'S NAME (Type) W. H. Morrison			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-56	
22c. NAME OF CEMETERY OR CREMATORY St. Mathews		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS	
24a. REC'D BY REGISTRAR Nov. 19, 1956		24b. REGISTRAR'S SIGNATURE Wm. Kelly	

RECEIVED

NOV 30 1956

BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar's signature and the date of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11157

10990 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4203 Maryland Place				d. STREET ADDRESS 4203 Maryland Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Alwin Wode				4. DATE OF DEATH Month Day Year 11-17-56 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1878		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Baker		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Hanover Germany		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William Wode				14. MOTHER'S MAIDEN NAME Leana			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Marie E. Wode, 4203 Maryland Place			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis, left with right hemiplegia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 6 , 19 56 , to Nov. 16 , 19 56 , that I last saw the deceased alive on Nov. 16 , 19 56 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert J. Leick		ADDRESS (Street, city or town, state) 5305 East Drive Baltimore Md 11/17/56					
DATE SIGNED 11/17/56							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-56		22c. NAME OF CEMETERY OR CREMATORY St Pauls		22d. LOCATION (City, town, or county) (State) Violetville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave				24a. REC'D BY REGISTRAR DATE 11-21-56		24b. REGISTRAR'S SIGNATURE Dr. Geo. Pfeiffer	

BUREAU 5.

NOV 21 1956

RECEIVED

11166 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McDonogh Md</u>		c. LENGTH OF STAY IN 1b <u>10 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18,</u>		3201-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1147 Gorman Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mamie Belle Working</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27, 1895</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles McDonald</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Shipley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT <u>Richard Working, McDonogh, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>10 Nov, 1956</u> to <u>10 Nov, 1956</u> that I last saw the deceased alive on <u>Dead on Arrival</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. <u>Deceased under Dr. Wm. Hammer's care for</u> <u>Hard disease.</u> ACTUAL SIGNATURE <u>Paul H Royse</u> M.D. <u>808 Reisterstown Rd</u> DATE SIGNED <u>10 Nov 56</u> PHYSICIAN'S NAME (Type) <u>Paul H Royse MD</u> <u>Pikesville 8 Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-14-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>Nov 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Jewell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 15 1950

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10
CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

THIS CERTIFICATE IS SUBJECT TO THE REVIEW OF THE DEPARTMENT OF HEALTH AND MAY BE REVOKED OR AMENDED AT ANY TIME.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11159
37

11167

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>1hr.1/2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Garrison Forrest Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Henrietta</u> Middle <u>Park</u> Last <u>Xanders</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1892</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henery Ingman Park</u>				14. MOTHER'S MAIDEN NAME <u>Lelle Chapman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harold L. Xanders, Garrison, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull & Left Clavicle & Ribs</u> INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fall down cellar steps</u> <u>1/2 hr.</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down cellar steps</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> a. m. <u>Nov. 22</u> 19 <u>56</u> b. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Friends home</u>		20f. (City or town) (County) (State) <u>Reisterstown, Balto., Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D.D. Caples</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D.D. Caples, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 24/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garrison, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville</u>				24a. REC'D BY REGISTRAR <u>NOV 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Anthony Newell</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		11-26-56		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		TITLE	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		J. H. HARRIS		M.D.	
CITY		STATE		COUNTY		ZIP CODE		HOURS		MINUTES	
BALTIMORE		MD.		BALTIMORE		21201		11		26	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS DEATHS		REMARKS	
11-26-11		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		0		NO OTHER DISEASES	
FATHER'S NAME		MOTHER'S NAME		SISTER'S NAME		BROTHER'S NAME		CHILDREN		REMARKS	
JAMES H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		JOHN H. HARRIS		3		NO OTHER DISEASES	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		SISTER'S OCCUPATION		BROTHER'S OCCUPATION		CHILDREN		REMARKS	
LABORER		LABORER		LABORER		LABORER		3		NO OTHER DISEASES	
FATHER'S RESIDENCE		MOTHER'S RESIDENCE		SISTER'S RESIDENCE		BROTHER'S RESIDENCE		CHILDREN		REMARKS	
BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		3		NO OTHER DISEASES	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		SISTER'S DATE OF BIRTH		BROTHER'S DATE OF BIRTH		CHILDREN		REMARKS	
11-26-11		11-26-11		11-26-11		11-26-11		3		NO OTHER DISEASES	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		SISTER'S PLACE OF BIRTH		BROTHER'S PLACE OF BIRTH		CHILDREN		REMARKS	
BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		3		NO OTHER DISEASES	
FATHER'S EDUCATION		MOTHER'S EDUCATION		SISTER'S EDUCATION		BROTHER'S EDUCATION		CHILDREN		REMARKS	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		3		NO OTHER DISEASES	
FATHER'S MARRIAGE		MOTHER'S MARRIAGE		SISTER'S MARRIAGE		BROTHER'S MARRIAGE		CHILDREN		REMARKS	
MARRIED		MARRIED		MARRIED		MARRIED		3		NO OTHER DISEASES	
FATHER'S PREVIOUS DEATHS		MOTHER'S PREVIOUS DEATHS		SISTER'S PREVIOUS DEATHS		BROTHER'S PREVIOUS DEATHS		CHILDREN		REMARKS	
0		0		0		0		3		NO OTHER DISEASES	
FATHER'S REMARKS		MOTHER'S REMARKS		SISTER'S REMARKS		BROTHER'S REMARKS		CHILDREN		REMARKS	
NO OTHER DISEASES		NO OTHER DISEASES		NO OTHER DISEASES		NO OTHER DISEASES		3		NO OTHER DISEASES	

BUREAU V. S.

NOV 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11160
Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		<u>3Y01-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ft. Howard Hospital</u>				d. STREET ADDRESS <u>537 Moore St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>W.</u> Last <u>YARBROUGH</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec 29, 1896</u>	9. AGE (In years last birthday) <u>59</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pittsboro N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>231-07-6250</u>		17. INFORMANT Address <u>Gladis Bullock 517 W. Biddle St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X HYPERTENSIVE CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY THROMBOSIS</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Paul F. Guerin</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>PAUL F. GUERIN</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>11-3-56</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 8, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Holston</u>				ADDRESS <u>918 Druid Hill Ave</u>		24a. REC'D BY REGISTRAR DATE <u>Nov. 5, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farkley</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. Prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH NO. 1110 DATE OF DEATH NOV 5 1956		PLACE OF DEATH Home STREET 1110	
NAME OF DECEASED JOHN W. YITAKOONH AGE 35		SEX M RACE Chinese	
BIRTH DATE NOV 5 1921 BIRTH PLACE YITAKOONH		OCCUPATION Unknown PRESENT ADDRESS 1110	
MARITAL STATUS Single EDUCATION High School		PRESENT EMPLOYER Unknown DATE OF DEATH NOV 5 1956	
CAUSE OF DEATH Myocardial Infarction MANNER OF DEATH Natural		SIGNATURE OF EXAMINER John W. Yitakoonh TITLE Medical Examiner	
SIGNATURE OF NEXT OF KIN John W. Yitakoonh TITLE Next of Kin		SIGNATURE OF WITNESS John W. Yitakoonh TITLE Witness	

RECEIVED
 NOV 7 1956
 BUREAU V. 2

PAUL F. GUERIN
 BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>519 Middle River Road</u>		d. STREET ADDRESS <u>519 Middle River Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mar y</u> First Middle Last		4. DATE OF DEATH <u>Nov.</u> Month <u>14</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Hanna</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Alberr F. Yeager, Sr.</u>		Address <u>519 Middle River</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Arteriosclerotic Cardio Vascular disease</u> (c) <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 5, 1956</u> to <u>Nov 14, 1956</u> that I last saw the deceased alive on <u>Nov 14, 1956</u> and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Baumgardner</u> M.D.		ADDRESS (Street, city or town, state) <u>Balto 6 Md</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>11/14/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>NOV 19 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Edith H. Hays</u>	

NOV 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11162

11170 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 75 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
4. DATE OF DEATH Month November Day 13 Year 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MOSES Middle H. Last YORK		4. DATE OF DEATH Month November Day 13 Year 1956	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/28/89	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Garage	
11. BIRTHPLACE (State or foreign country) Harrisonburg, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley York		14. MOTHER'S MAIDEN NAME Phyllis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 213-01-0579	
17. INFORMANT Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS WITH METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 30 , 19 56 , to November 13 , 19 56 , and that death occurred at 5:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED		21. I certify that I attended the deceased from August 30 , 19 56 , to November 13 , 19 56 , and that death occurred at 5:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE WALTER J. PIJANOWSKI, M. D.		M.D. VAH, Fort Howard, Maryland	
PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M. D.		DATE SIGNED 11/13/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson, Inc., 916 Pa. Ave., Balto., Md.		ADDRESS William A. Jackson, Inc., 916 Pa. Ave., Balto., Md.	
24a. REC'D BY REGISTRAR NOV 19 1956		24b. REGISTRAR'S SIGNATURE Lawson L. Tucker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10991 CERTIFICATE OF DEATH

11163

Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1026 Leeds Avenue				d. STREET ADDRESS 1026 Leeds Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anna Middle M. Zinnell Last				4. DATE OF DEATH Month November Day 19 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1885		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hyland Pennington				14. MOTHER'S MAIDEN NAME Ann R. Reiter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. William Zinnell 1026 Leeds Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A. S. C. V. D. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/9 , 19 55 , to 11/19 , 19 56 , that I last saw the deceased alive on 11/18/56 , 19 56 , and that death occurred at 12:08 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Kelly M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Hatfield, Md 11/19/56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/23/56		22c. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery Baltimore Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Avenue				24a. REC'D BY REGISTRAR DATE 11-21-56		24b. REGISTRAR'S SIGNATURE Dr. J. S. Kieffer	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		MALE		WHITE	
BIRTH DATE		BIRTH PLACE		MOTHER'S MAIDEN NAME	
MAY 19, 1932		MEMPHIS, TENNESSEE		JAMES EARL RAY	
OCCUPATION		EDUCATION		MARRIAGE	
ATTORNEY		HIGH SCHOOL		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
HEART DISEASE		NATURAL		100-100000	
TIME OF DEATH		PLACE OF DEATH		SIGNATURE OF REGISTRAR	
10:00 AM		MEMPHIS, TENNESSEE		JAMES EARL RAY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF REGISTRAR	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. E.

APR 21 1968

RECEIVED